PROPOSALS TO REDUCE MEDICARE OUTLAYS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JULY 27, 1990

Serial No. 101-184

Printed for the use of the Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE

36-375 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
PHILIP R. SHARP, Indiana
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
AL SWIFT, Washington
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W.J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas
DENNIS E. ECKART, Ohio
BILL RICHARDSON, New Mexico
JIM SLATTERY, Kansas
GERRY SIKORSKI, Minnesota
JOHN BRYANT, Texas
JIM BATES, California
RICK BOUCHER, Virginia
JIM COOPER, Tennessee
TERRY L. BRUCE, Illinois
J. ROY ROWLAND, Georgia
THOMAS J. MANTON, New York
EDOLPHUS TOWNS, New York
C. THOMAS McMILLEN, Maryland

NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
DON RITTER, Pennsylvania
THOMAS J. BLILEY, Jr., Virginia
JACK FIELDS, Texas
MICHAEL G. OXLEY, Ohio
HOWARD C. NIELSON, Utah
MICHAEL BILIRAKIS, Florida
DAN SCHAEFER, Colorado
JOE BARTON, Texas
SONNY CALLAHAN, Alabama
ALEX McMILLAN, North Carolina

JOHN S. ORLANDO, *Chief of Staff*
JOHN M. CLOUGH, JR., *Staff Director*
MARGARET A. DURBIN, *Minority Chief Counsel/Staff Director*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, California, *Chairman*

JAMES H. SCHEUER, New York
RON WYDEN, Oregon
GERRY SIKORSKI, Minnesota
JIM BATES, California
TERRY L. BRUCE, Illinois
J. ROY ROWLAND, Georgia
EDOLPHUS TOWNS, New York
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
RALPH M. HALL, Texas
DENNIS E. ECKART, Ohio
BILL RICHARDSON, Mew Mexico
JOHN D. DINGELL, Michigan,
(Ex Officio)

EDWARD R. MADIGAN, Illinois
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
THOMAS J. BLILEY, JR., Virginia
JACK FIELDS, Texas
HOWARD C. NIELSON, Utah
MICHAEL BILIRAKIS, Florida
NORMAN F. LENT, New York
(Ex Officio)

KAREN NELSON, *Staff Director*
MICHAEL M. HASH, *Senior Staff Associate*
HOWARD COHEN, *Minority Counsel*

CONTENTS

PROPOSALS TO REDUCE MEDICARE OUTLAYS

FRIDAY, JULY 27, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m. in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Today's hearing is intended to explore a number of proposals that have been advanced to reduce Medicare outlays as a part of our efforts to reduce the Federal deficit in the coming fiscal year. While this is an increasingly difficult and risky undertaking, this year we are in the awkward position of not yet having a budget resolution for fiscal year 1991.

We had hoped to schedule these hearings at such time that witnesses would be able to take account of proposed Medicare reductions included in the budget resolution in their testimony to the subcommittee. Although the budget summit now in progress may yet reach an agreement, we felt the subcommittee should proceed with consideration of those Medicare cuts included in the President's budget and those additional proposals that have been presented in the summit negotiations, as well as selected legislative proposals referred to the subcommittee.

It is disturbing to hear reports that the budget summit agreement may include legislative initiatives that would be developed outside of formal consideration by the committees of jurisdiction. I would hope that the budget summit will reach an agreement that recognizes the responsibility of the committees to determine the specific policy or statutory changes that are necessary to achieve appropriate deficit reduction targets.

Moreover, I believe it is essential that a multiyear budget agreement include the opportunity for health care initiatives such as those advanced by the Pepper Commission.

As we begin our formal consideration of Medicare-related reconciliation proposals, I believe it is important to underscore the fact that in the last two budget reconciliation acts, OBRA 87 and OBRA 89, Congress agreed to substantial Medicare payment reductions. Specifically, OBRA 87 included 3-year savings of $4.7 billion and OBRA 89 had 5-year Medicare savings of $5.4 billion.

At the same time, we have put into place a number of new payment methodologies for services and supplies covered under part B

of Medicare. In my judgment, further, deep reductions in part B could seriously disrupt implementation of payment reform policies, and place beneficiaries at increased financial risk for the cost of needed care.

I am especially alarmed about the serious consideration being given to proposals to increase the portion of part B program costs borne by beneficiaries through premiums and the annual deductible. Such changes are completely counter to efforts by this subcommittee to extend financial protection to beneficiaries. Such policies fall especially hard on those low-income beneficiaries who are not eligible for Medicaid and do not have private supplemental insurance.

It is also important to remember that these policies also shift costs to the States that are required to provide Medicaid coverage of these amounts for certain low-income elderly residents.

Because Medicare payment cuts have become virtually an annual routine, too many in Congress may believe such reductions can continue without any adverse consequences. Already, we are seeing signs of access and quality problems that, in part, can be linked to inadequate financing of the Medicare program, especially in isolated rural areas and in our inner cities.

With the likelihood that these problems will become more frequent and acute, we must take care to assess the impact of future payment reductions. The payment reforms we have put in place in recent years represent a careful balance between prudent purchasing and fair compensation. We must not adopt Medicare budget targets that require payment cuts that are inconsistent with these policies, or that impose regressive financing obligations on beneficiaries.

I recognize that deficit reduction must be a high priority in Congress. At the same time, we must not destroy those essential Federal health programs on which millions of Americans depend. I look forward to the testimony of our witnesses this morning and their assistance in this challenging task.

Before I call on our witnesses, I want to recognize members of the subcommittee. I call on Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman.

It is certainly disquieting to me to see the continued cuts that are being proposed in Medicare, whether it is $1.7 billion, $2 billion or $5 billion. Certainly we need to address the budget deficit problem that we have, but if one looks into the rural areas, as you have already mentioned, and what is taking place there relative to providing health care and teaching institutions in the more urban areas, one must become increasingly concerned with the problems that we are facing in our health care delivery system.

And so, I am very concerned about the proposed cuts we are talking about in Medicare. Certainly, there are other areas we could go to without increasingly disrupting our health care delivery system.

I am looking forward to what the witnesses have to say this morning, also; and again, I commend you for having this hearing.

[The opening statement of Mr. Rowland follows:]

OPENING STATEMENT OF HON. J. ROY ROWLAND

Mr. Chairman, I believe that budget cuts have to be considered in virtually every government program in our efforts to meet deficit-reduction targets.

Having said that, I want to express my deepest concern over the Draconian cuts that are now being discussed for Medicare.

The kind of huge Medicare cuts that are reportedly now under consideration could do extreme harm to our health care system. It's true that deficits threaten substantial long-term economic damage. But I believe there are options that would be less harmful to the country.

It appears to me that we are getting desperate in our attempts to reach the Gramm-Rudman-Hollings targets, and this desperation is driving us toward cures that may be worse than the disease.

Medicare has experienced countless cuts and regulatory changes in recent years. Patients and providers alike are demoralized. They want stability and improvement. Instead, we're talking about even bigger cuts which threaten further limits on patient care.

Mr. Chairman, I'm pleased that our subcommittee is looking into this issue and I hope we can help provide alternatives that are better for the country.

Mr. WAXMAN. Mr. Nielson.

Mr. NIELSON. I have no formal prepared statement, but I would say it is a very important topic. I was distressed with the President's budget, which seems to single out Medicare as one of the areas to cut, although you have had rising costs, something we cannot cut.

Maybe we can cut the amount per patient, but we can't cut the number of patients who qualify for particular needs, nor can we encourage the hospitals to use a factory method to get the patients out faster to save costs, so we have a problem there.

Medicare is one of the eight programs which is protected from Gramm-Rudman cuts. If we choose to go the Gramm-Rudman route, then Medicare will be protected in that regard. I think that would be helpful.

As I have talked to doctors throughout my large rural district—I find that they are very discouraged. They are upset about the slowness of the payments.

Many people who will not take Medicare patients; many doctors' sons are electing not to go into medicine because of the general discouragement in that area. We do have a problem. We have to get a handle on the costs. It is important we save where we can save. We streamline the red tape in some cases, which I think would help some of the costs.

And we need to do as much as we can. I think that the medical profession has taken its lumps over the years. They have taken the decreasing payments before we froze other payments. After the doctors froze their payments in 1983, we forced them to freeze them the next 2 years. which is not a good reward.

I am quite sympathetic to the needs of the health industry, and I appreciate the chairman's having this hearing.

Mr. WAXMAN. Thank you very much, Mr. Nielson.

Our first witness has appeared before our subcommittee on a number of occasions, and provided us very valuable assistance in reviewing complex issues. Dr. Paul Ginsburg is the executive director of the Physician Payment Review Commission, the advisory body to the Congress and to the Secretary of HHS on physician and other practitioner payment policy issues.

Dr. Ginsburg, we are pleased to welcome you to our subcommittee. You have some recommendations for us. Your prepared statement will be in the record in full. We would like to ask, if you would, to limit your oral presentation to no more than 5 minutes.

STATEMENT OF PAUL B. GINSBURG, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. GINSBURG. I am pleased to do that. I am pleased to be here on behalf of the Physician Payment Review Commission. I want to discuss two topics in my oral remarks: One is the Commission's recommendation to Congress on the volume performance standard for 1991, and the other is our budget reduction recommendations that were prepared at the request of the Ways and Means and Finance Committees.

In its May 15 report to Congress, the PPRC commented on the Secretary's Medicare volume performance standard recommendations, and made its own. Our recommendation was a somewhat higher number overall—a 11.2 percent increase versus a 9.9 percent, and a larger difference between the surgical and nonsurgical performance standards of an additional 1 percentage point.

The Commission used a different approach than the Secretary. First, it discussed its long-term goals, and the Commission decided on a long-term goal to slow the growth of expenditures to that of GNP, over a 5-year period.

Concerning the short-term recommendations, they were based on an assessment of the capacity of the medical profession to reduce the rate of growth of volume through guidelines and other mechanisms.

The Commission used the Medicare actuary's projection of base line expenditure increases and made the judgment that growth could be slowed by 2 percentage points from that.

Concerning the surgical and nonsurgical difference, our analysis using the most recent year's data shows there has been lower volume growth in surgery. The leveling off of the growth of cataract surgery in 1990 suggests an increased differential between surgery and nonsurgery.

The Secretary limited his recommended differential to the effects of prior legislation, and the Commission recommends an increase of a conservative 1 percentage point to reflect a portion of the differences in trends.

Concerning budget reductions for 1991, as in the past, the Commission has strived to make its recommendations consistent with payment reform. And now that payment reform has been enacted, an additional consideration of avoiding jeopardizing the successful implementation of the payment reform has been uppermost in the Commission's mind.

This means attempting to limit instances of changing payments in the wrong direction, or overshooting the mark, and also limiting the magnitude of reductions. The Commission feels it is important to limit the magnitude of the reductions, both to provide time for physicians to adjust to the new payment system and to give private payers time to follow Medicare's lead, in order to avoid large dis-

crepancies between what Medicare pays and what private payers pay.

The rumors from the budget summit suggest there could be a savings objective much higher than has been planned by Congress to date. And if so, the savings requirement could exceed the total of what the Commission has recommended.

The Commission feels that deeper cuts are possible, but would substantially increase the risks to successful implementation of the payment reform program.

In addition, meeting the targets that come out of the budget summit for physician payments are particularly hard, because of the savings estimating assumptions that are used by the actuary and the Congressional Budget Office, particularly assuming that changes in behavior by physicians will offset 50 percent of any savings from fee constraints.

This assumption does not have a very strong basis in the research literature, and its importance to policy is truly enormous.

One final comment I have is on the issue of balance billing limits in 1991. The difference between the beginning date of the balance billing limits and the beginning of the fee schedule has caused an unintended situation of reduction in Medicare revenues for some services that are deemed to be undervalued, although the situation is not widespread.

The Commission, in response to this problem, has proposed raising the floor on primary care services that was originally enacted at this committee's suggestion in OBRA 1987. By raising the floor to 65 or 75 percent of the national mean, a substantial part of this problem could be eliminated.

This concludes my remarks, and I am pleased to have my full statement in the record.

[Testimony resumes on p. 18.]

[The prepared statement of Mr. Ginsburg follows:]

Statement of the

Physician Payment Review Commission

Mr. Chairman, I am pleased to testify on behalf of the Physician Payment Review Commission to discuss budget proposals to slow the rate of increase in Medicare expenditures for physicians' services. It is the Commission's judgment -- shared by the Congress -- that growth in physician expenditures must be slowed to a lower, sustainable rate. This is reflected in the Commission's past work to outline budget savings for the Congress and in its work on expenditure targets, which assisted the Congress in creating a system of Volume Performance Standards (VPS).

My statement has three parts. The first describes the Commission's Volume Performance Standard recommendation for fiscal year 1991. The second outlines the approach used by the Commission in developing its Medicare budget recommendations for that year. The third describes the options it recommends.

VOLUME PERFORMANCE STANDARDS FOR FISCAL YEAR 1991

The system of Volume Performance Standards created by the Omnibus Budget Reconciliation Act of 1989 (OBRA89) provides a long-term, collective incentive to physicians to slow growth in Medicare expenditures to sustainable levels. The Commission believes that this can be accomplished within five years while maintaining access and quality of care.

Commission Recommendations

In April the Secretary recommended a VPS rate of increase for FY1991 of 9.9 percent for all services, 8.7 percent for surgery, and 10.5 percent for nonsurgical services. This standard makes full allowances for expenditure growth due to inflation, increases in enrollment, increases in the average age of beneficiaries, and the effects of prior legislation. It also provides an allowance for

increases in volume and intensity per enrollee of one-half of the Department's estimated annual growth of expenditures from FY1986 to FY1990.

In its May 15 report to Congress, the Commission reviewed the Secretary's recommendation and made its own recommendation of 11.2 percent overall, with separate standards for surgical services and nonsurgical services of 9.3 percent and 12.1 percent respectively.[1]

Although the Commission's and the Secretary's performance standards differ primarily due to the Secretary's lower allowance growth of volume and intensity, the Commission also used somewhat different reasoning in developing its recommendations. Because it is not possible to develop accurate projections on the effects of new technology, access, and appropriateness on expenditures, the Commission began with the Medicare Actuary's baseline projection for expenditure growth and then decided upon the reduction in growth that could be achieved without threatening beneficiary access or the quality of care. This approach is particularly appropriate for the initial years under the VPS system, when the ability of physicians to affect medical practice is the primary factor limiting the pace at which the growth rate can be slowed.

The Commission judged that the rate of growth could be reduced by two percentage points from the baseline by eliminating services of little or no benefit to beneficiaries. In effect, the Commission allowed full increases for the other factors specified in the legislation but judged that the medical profession can reduce growth by slowing growth of volume and intensity of services without compromising access or quality of care.

---

[1] See Physician Payment Review Commission, Medicare Volume Performance Standard Rate of Increase for Fiscal Year 1991, No.90-1, May 15, 1990.

The Commission also recommended separate VPS rates of increase for surgical and nonsurgical services that are one percentage point farther apart than the Secretary's. This reflects evidence that the Medicare volume of surgical services has grown less rapidly in recent years than that of nonsurgical services. The volume of cataract surgery has also levelled off, suggesting that growth in surgical volume has fallen further behind that for nonsurgical services.

The Challenge of Volume Performance Standards

The challenge of making Volume Performance Standards work over the long term will fall primarily to the medical profession because only physicians can identify and reduce services of little or no benefit. Medical organizations have recently begun or have accelerated the development and use of practice guidelines. To build on these initial efforts, the profession must receive strong support from the Department of Health and Human Services, particularly the new Agency for Health Care Policy and Research and the Health Care Financing Administration.

Volume Performance Standards are taking us into new territory. While other nations have held expenditure growth in health care to levels they consider affordable, none has done so within a system as fragmented and pluralistic as ours. And no society has resolved to develop the information needed to determine how best to spend their health care resources, as we seek to do through research on effectiveness and outcomes.

We have an unprecedented opportunity not only to bring expenditure growth to a sustainable level, but to maintain access and quality and to improve the value received for these expenditures. Over the long term, the Commission believes that controlling volume via Volume Performance Standards will be far more effective than continually cutting prices. Accomplishing this goal will require

prudent and thoughtful management of the Volume Performance Standard system by the Congress, and strong support by the federal government for the medical profession.

THE COMMISSION'S APPROACH TO DEVELOPING BUDGET PROPOSALS

In previous years when the Congress sought the Commission's advice on options for program savings, our recommendations were guided by the principle that any short-term changes to reduce projected outlays should move in the direction of longer-term reform. Past recommendations assisted the Congress in establishing the precedents of protecting primary care services from budget reductions and focusing reductions on procedures that are overvalued and on geographic areas where current payments are highest.

In developing its proposals this year, the Commission once again sought options consistent with long-term reform as now embodied in the landmark reform of Medicare physician payment enacted in OBRA89. Although the Commission believes that savings in the long run will be achieved primarily through Volume Performance Standards, savings for the coming fiscal year can only be achieved by prudent cuts in prices. In doing so, the Commission first sought to avoid moving relative values in a direction inconsistent with the Medicare Fee Schedule (for example, "overshooting the mark"), since such a change would be reversed when the fee schedule is implemented. Second, it considered the extent to which fees could be reduced without jeopardizing the successful implementation of payment reform.

The Bush Administration has proposed large reductions in Medicare physician services for fiscal year 1991. Although most of their proposals would move payment levels in the right direction, they would move the system too far too soon. Increasing the speed or the magnitude of fee reductions

to achieve budget savings as recommended by the Administration could undermine the objective of orderly change and erode the good faith of physicians and beneficiaries who supported a reform that was years in the making. Sharply increasing the discrepancies between Medicare fee levels and those of private payers could also increase the risks of limiting access for Medicare beneficiaries.

The transition schedule spelled out in OBRA89 is already quite rapid and the anticipated changes in payment rates for many physician services are substantial. Between reductions in prevailing charges for overvalued procedures that took effect earlier this year and the first implementation phase of the Medicare Fee Schedule that begins in January 1992, a substantial proportion of the payment changes projected under the fully implemented fee schedule will have been made. In localities with high charges (for example, Los Angeles, New York and Miami), cumulative reductions in OBRA89 overvalued procedures will total 23 percent by 1992. For some physicians, limits on balance billing will reduce their revenues from these services by an even larger margin.

An orderly transition is also critical to minimize discrepancies in payment rates between Medicare and other payers. While initial indications suggest that many private payers and state Medicaid programs will follow Medicare's lead, it will take some time before they can actually decide on and implement payment changes. By beginning implementation of the fee schedule in 1992 and stretching the transition over several years, Congress provided time for other payers to make adjustments before the fee schedule is completely in place. Accelerating this transition to achieve savings could lead to substantial payment differences and pose risks to beneficiary access.

The Commission recognizes that the outcome of the budget summit discussions now underway may necessitate more substantial Medicare cuts than have been planned by the Congress to date. If

needed, deeper cuts than suggested in the following section of this statement are possible, but would increase the risks to successful implementation of payment reform. Like the cuts already recommended by the Commission, additional steps should include a mix of selective and across-the-board reductions.

Meeting a large Medicare savings target is made particularly difficult by the assumption made by the Medicare Actuary and the Congressional Budget Office that 50 percent of the savings from constraining or reducing allowed charges would be offset by increases in the volume of services.[2] This assumption implies, for example, that allowed charges would have to be reduced by 10 percent to achieve a 5 percent reduction in outlays. Evidence to support this assumption is very limited and appears to be inconsistent with the Medicare experience since 1984 when substantial physician payment reductions began. Although this is a technical issue, the implications for policy are enormous.

SPECIFIC BUDGET PROPOSALS

In developing its recommendations, the Commission examined a number of options. It requested comments on an initial set of options from a wide range of interested parties and carefully considered their comments and suggested alternatives. The specific budget proposals are discussed below. A letter from the Commission to the House Ways and Means Subcommittee on Health that describes these proposals in greater detail is also submitted for the record.

---

[2] The Commission is also concerned that this assumption has been applied inconsistently. Preliminary estimates of an option to raise the floor under prevailing charges for primary care services do not reflect an offset for reduced volume of services.

Reduction in MEI Update

Outlays could be reduced by either reducing or eliminating the update in prevailing charges for physician services. The Commission recommends two exceptions. Primary care services should receive the full update; a smaller reduction should be made in the update for hospital visits than for other non-primary care services.

The reductions in updates proposed by the Commission are consistent with the direction of physician payment reform. Giving a full update to primary care would provide a relative increase to those services that will increase under the fee schedule. And since most non-evaluation and management services will decrease under the fee schedule, reducing or eliminating their update would also move them closer to their fee schedule values. This broad-based reduction would result in substantial savings in outlays without sharply reducing the prevailing charge for any individual service.

The Commission also recommends raising the geographic floor for prevailing charges of primary care services that was established in OBRA87. This floor, which was set at 50 percent of the national average prevailing charge for participating physicians without regard to specialty, weighted by frequency of service in each locality, could be set at a higher fraction of the national weighted average, such as 65 to 75 percent. This would raise prevailing charges in areas that are now unusually low and ensure that each primary care service would be paid at least that threshold amount in all geographic areas. If the floor were raised substantially, it would also prevent most of the reduction in practice revenue that primary care physicians will experience due to the imposition of balance billing limits prior to fee increases.

Overvalued Procedures

Last year, Congress reduced prevailing charges for 245 procedures estimated to be "overvalued" by comparison to an estimated Medicare fee schedule after geographic adjustment in each locality. To prevent large cuts in one year, this reduction was limited to 15 percent for any prevailing charge in a locality. The Commission does not recommend substantial additional reductions for these procedures, but does recommend that Congress complete the one-third reduction for those prevailing charges that were limited by the 15 percent rule last year. In effect, this would bring those charges that had been unusually high relative to the fee schedule to the same point that has already been reached by most of the overvalued procedures. This additional reduction could be limited to 15 percent.

The large reductions proposed by the Administration (two-thirds of the remaining difference up to a maximum of 25 percent) would pose substantial risk of "overshooting the mark." That is, it could reduce prevailing charges for some of these procedures below their eventual levels in the new fee schedule. This could pose risk to beneficiary access for these services and would detract from the credibility of payment reform.

Further, the Commission does not have the necessary data to support additional reductions for these overvalued procedures or to allow it to identify additional overvalued procedures. The reductions recommended by the Commission last year and enacted in OBRA89 were based on physician work estimates from the first phase of the Hsiao study and the Commission's initial work on practice costs. The magnitude of those reductions reflected the confidence placed in those estimates. Since that time, nothing has changed to give the Commission increased confidence in its estimates, nor is there data for additional specialties. More accurate data will not be available

once Phase II of the Hsiao study and the Commission's work to develop practice expense components for the fee schedule are completed. These results are not expected before Fall 1990 at the earliest.

Radiology, Anesthesia, and Anatomic Pathology

The Commission recommends an average reduction in prevailing charges of up to 4 percent for radiology, anesthesiology, and anatomic pathology services. By most estimates, these services are substantially overvalued and will be reduced under the fee schedule.

Projected outlays could be reduced for most radiology services by reducing the conversion factors for the Radiology Fee Schedule. Most of these conversion factors exceed the values they will have when the Medicare Fee Schedule is implemented. Reductions should be scaled geographically so that those conversion factors that are now the highest, after adjustment by the Geographic Cost of Practice Index (GPCI), would be reduced the most, and conversion factors that are already low would not be reduced at all. Where feasible, these reductions could apply only to the professional component of radiology global services.

Outlays for anesthesia services could also be reduced by lowering conversion factors. The Commission recommends reducing only the higher area conversion factors, as described above for radiology, with a limit of 15 percent in any area.[3] The Commission also recommends extension of the OBRA87 provision that limits charges for supervising more than one certified registered nurse anesthetist (CRNA) at the same time. Since this provision expires at the end of 1990, an extension

[3] The American Society for Anesthesiology (ASA) proposed a different method to adjust the conversion factor reductions geographically. The ASA's proposals would not limit the conversion factor reductions to those that are now highest.

would produce budget savings.

Outlays could also be limited by reducing prevailing charges for anatomic pathology services, preferably in conjunction with a geographic floor. The Commission recommends reducing all prevailing charges in each area by a uniform amount that would reduce the average prevailing charge by up to 4 percent, but exempting areas where the weighted average of prevailing charges is already below a threshold of, for example, 70 percent of the national average. Prevailing charges in these low areas would not be reduced at all, and those in other areas would not be reduced below this level. Although varying the reduction for each prevailing charge according to its level in each area would result in more precise reductions, variations across areas in the use of procedure codes makes this precision more apparent than real. Consequently, the Commission recommends the simpler approach described above.

These proposals make a moderate move to adjust radiology, anesthesiology and anatomic pathology toward their fee schedule values. The Commission's recommendations would be equitable to physicians across geographic areas by adjusting the widely divergent conversion factors that are currently used in the anesthesia and radiology fee schedules.

Assistants at Surgery

There is evidence that a substantial fraction of the use of assistants at surgery is discretionary and in some cases unnecessary. Although outlays could be reduced by eliminating payment for assistants at surgery when they are not justified,[4] sound policies to accomplish this have not been

[4] It is not clear how much could be saved even if all unnecessary payment for assistants were eliminated. This is because assistants are necessary for many complex and expensive surgical procedures such as open heart operations.

developed. The Commission is working to develop methods to eliminate unnecessary use without jeopardizing payment when use of an assistant is medically necessary, but these alternative proposals will not be ready for legislation this year.[5]

The Administration has proposed paying the same amount for a surgical procedure regardless of whether an assistant is used. Any payment to the assistant would be deducted from the payment to the primary surgeon. This policy could reduce beneficiaries' access to needed surgical assistance, and would seem to require a form of fee splitting, a practice that violates deeply held professional principles.

The decisions to use an assistant at surgery and whether that assistant should be a physician, a physician assistant (PA) or a nurse lie primarily with the operating surgeon. Each decision depends on many factors. These include the complexity of the operation itself, the clinical condition of the patient, the availability of nurses, physician assistants, and housestaff. Any policy to influence the use of assistants should recognize the complexity of this decision. Consequently, the Commission has begun to explore ways to influence surgeons' decisions as well as ways to monitor their use of assistants.

The Commission is examining three options for monitoring and influencing physicians' use of assistants: (1) feedback from their peers about rates of use by the individual physician or by physicians in the area, (2) profiling of use of assistants with request for justification from those surgeons who use assistants at a substantially different rate than their peers, and (3) prior authorization for payment for some or all assistants.

---

[5] The Commission will report to the Congress by July 1, 1991, on payment for assistants at surgery, as directed in OBRA89.

The Commission would prefer to use peer feedback to influence physicians, an approach that has been successful in reducing high utilization rates for some services in the Maine Medical Assessment Project and in other settings. It is particularly appropriate when multiple clinical factors make it difficult to write simple rules for the use of assistants. Feedback could be coupled with the development and use of practice guidelines in this area.

The Commission is also exploring the utility of profiling to monitor and influence the use of assistants. Profiling each surgeon's use would provide information to Medicare and surgeons about their practice compared to either their peers or to guidelines. Alternatively, carriers or peer review organizations could request justification from surgeons whose patterns of use differ substantially from the norm. This option would be less intrusive than either case-by-case review or prior authorization.

Finally, prior authorization could be required for payment of the assistant. However, this method is costly and intrusive. It may also be difficult for third parties to make determinations as to when an assistant is needed. Prior authorization might be more effective if targeted to a subset of operations that are thought to need an assistant very infrequently.[6] Prior authorization could also be employed only where other methods, including profiling and feedback, had failed.

The Commission is not ready to recommend an approach to reducing unnecessary use of assistants for implementation or budget savings in 1991, but intends to do so no later than its April 1991 report to Congress. The Commission first must gain a better understanding of existing patterns of use of assistants and the factors that influence them. With that knowledge, the Commission anticipates developing an effective method for reducing unnecessary use of assistants at surgery.

[6] For example, prior authorization could be required only for operations for which assistance is not routinely used, and for which the rate of use varies substantially among payment areas.

Mr. WAXMAN. In developing the Commission's recommended Medicare volume performance standard for 1991, you indicated it was the Commission's judgment projected growth and outlays could be cut by 2 percentage points without threatening beneficiary access or the quality of care.

Could you elaborate on the evidence the Commission relied upon to reach this recommendation?

Mr. GINSBURG. The Commission attempted to estimate, first of all, the magnitude of services that are inappropriate, and also the fiscal implications of technological change on the Medicare program. It found, in both instances, very little data to go on. The Commission, rather than trying to estimate these, became very familiar with all the activities that were being pursued as far as guideline development, some of the fragmentary evidence of the proportion of certain specific services that were inappropriate or unnecessary. It then made a careful judgment that with this activity, that by fiscal year 1991, perhaps the sum total of these effects could slow the volume growth by 2 percentage points.

It is very much judgment. We don't have a lot of objective information to justify that 2 percent.

Mr. WAXMAN. Has the PPRC identified any evidence physician payment reductions already in place have resulted in physicians limiting their Medicare practices or reducing the number of claims taken under assignment?

Mr. GINSBURG. We haven't seen any objective evidence of that. Actually, the assignment rate continues to be at a high level. But, nevertheless, we have heard quite a bit of anecdotal evidence of physicians mentioning, as far as new patients are concerned, they are limiting access to Medicare patients.

And we are quite concerned about that, but we haven't seen any objective evidence that access has deteriorated.

Mr. WAXMAN. How fast would we see some of the consequences of the Medicare changes? Wouldn't it take several years. For example, we have made deep cuts in Medicare in the hope we are not doing any great harm, but we won't know for 1 year, 2, 3, 4—how long would it take before we would have specific evidence?

Mr. GINSBURG. I think it would take a number of years. We do, unfortunately, now have a significant lag in the availability of claims data, in a sense, that we——

Mr. WAXMAN. How long a lag?

Mr. GINSBURG. Now we have 1988 data available to us. And with the implementation of the common working file, we do expect this data lag to shrink substantially, so we have data with really just a lag of a few months. But this is something that will not be fully implemented, I believe, until some time in 1991.

I think it is a problem, Mr. Chairman, to detect barriers to access that Medicare beneficiaries experience. And while I am optimistic about the improvements in data, such as the administration going forward with the current beneficiary survey, that are going to help in doing this.

But I think it is—it will always have imperfect means of detecting the effects of our payment decisions.

Mr. WAXMAN. I am particularly interested in the point you raise concerning the HCFA and CBO assumption that half of any sav-

ings from limiting charges of physicians is offset by increases in the volume of services.

You point out this assumption may not be applied to estimates that increase payments to physicians, that is, a reduction in the cost of such proposals to recognize the decline in the volume of services. Would you comment on this rather technical but critical budget scoring policy?

Mr. GINSBURG. Yes. The research in this area is very limited. There has been some evidence from past studies that there has been a response to fee reductions by increases in volume, but I think the most important piece of evidence is the experience with Medicare since 1984. As you mentioned before, year after year, Congress has made very substantial cuts in physician payments, and, nevertheless, the trends in the rate of growth of volume of service to Medicare beneficiaries does not seem to have increased in conjunction with these substantial fee reductions.

So, in a sense, we feel the recent experience really casts doubts that the magnitude of the assumption—50 percent—is excessive.

Another point is that none of the research that is available addresses what happens with continual constraints on reductions year after year. All of the research focuses on the initial response to a single reduction. And there are reasons to expect that over time, these responses could be smaller.

One final concern is that in the last two budget reconciliation bills, the reductions in services have focused on surgical procedures, where it is very difficult to comprehend that physicians could substantially increase the volume of those procedures in response to constraints on what they are paid.

So the orientation of the cuts also leads to a view that the 50 percent assumption is very excessive.

Your final point is about the—how the increase in the prevailing charge floor for primary care was costed, and there is evidence that when fees have increased, that volume has fallen. And, also, in many cases, what this primary care floor would do is simply minimize the reduction or reduce the reduction in revenue that physicians face, and clearly should have an assumption that is symmetric with the assumption that is used for budget reductions.

Mr. WAXMAN. Thank you very much.

Mr. Nielson.

Mr. NIELSON. I wonder if you would mind commenting on the President's budget this year? Medicare took a rather large reduction in that budget proposed, and while the Budget Committee did not follow the recommendations, in fact increased it slightly, how feasible—and be as blunt as you like—how feasible is it to cut the total amount for Medicare?

Mr. GINSBURG. I think the President's proposals were feasible in a sense they could be done. The issue is the consequences of doing them.

Mr. NIELSON. What were the consequences? What are the consequences?

Mr. GINSBURG. Those reductions would pose very serious risks to beneficiary access. They would be disruptive, because the magnitude of some of the reductions is so sharp. For example, in radiology, the President proposed a 10 percent reduction with—and this

affects the specialist's entire practice, with up to 25 percent reduction for individual areas.

The assistant at surgery proposal is basically not to pay for assistants at surgery; for certain procedures that routinely require an assistant, this would be tantamount to a 20 percent reduction in the surgeon's fee.

Mr. NIELSON. Could they lead to using physician assistants rather than physicians in some instances?

Mr. GINSBURG. That is possible, since physician assistants are paid by Medicare at only 65 percent of the rate physicians are.

Mr. NIELSON. Could they reduce the number of second opinions requested?

Mr. GINSBURG. I don't think they would have any effect on that, because they would still be paid separately.

Mr. NIELSON. Do you think it would have any impact on the use of generic drugs, for example, to force physicians to prescribe generic drugs?

Mr. GINSBURG. I don't think it would have any effect, because Medicare's only coverage of drugs are those prescribed in inpatient setting, and that is paid under the DRG's.

Mr. NIELSON. Would it force hospitals—not force them, but give them the excuse to discharge the patients perhaps prematurely?

Mr. GINSBURG. I doubt that any of these physician payment proposals would have a substantial effect on hospital behavior.

Mr. NIELSON. What about the impact on the morale of physicians and those prospective physicians? Would that make it so it would be more difficult to have a corps of medical personnel for rural areas, for example?

Mr. GINSBURG. I am very concerned with how low the payment rates are for rural areas now. Many of us look forward to the effect that the payment reform is going to have. But the extent to which whatever budget cuts are made this year will, in a sense, affect the total number of dollars that are available for the fee schedule when it begins in 1992 will result in a smaller increase in payments for rural areas than had been planned on when the payment reform was enacted.

Mr. NIELSON. As members of the committee know, I am a numbers man. Explain to me in words that an average person could understand how, if the number of people needing Medicare is going up, and the health care costs have not reduced, and all the components are tending to go up, how you can get the product of those two to come down?

Mr. GINSBURG. When we talk about budget cuts or savings, usually it is measured from a projection of what will happen under current law. So that even fairly sharp proposals to cut the budget usually will leave an increase in the actual dollars spent in Medicare, though a much smaller increase than had been projected under current policy.

So, no matter what is done, it is generally expected that because of rising medical costs, changes in technology, and the increase in the number of beneficiaries, that, in the aggregate, the Medicare budget will continue to increase, however constrained it is.

Mr. NIELSON. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Nielson.

Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman.

I am really concerned about beneficiary access, patients having access to physicians. Mr. Nielson mentioned the discontent he hears among physicians. I hear the issues.

You say you have heard anecdotal evidence of this type of problem, but no objective evidence of any decrease in participation. The level is quite high at this time. We hear these—we hear these anecdotal events, but I am just wondering how long it will be before we actually begin to see some objective evidence if that will in fact take place.

It seems to me that we can't continue to hear this type of talk without something objective becoming evident. Can you comment on that? Do you have any concern about that?

Mr. GINSBURG. Actually, the Commission addressed this directly and felt that at this point in time, in 1990, that access of Medicare beneficiaries to physician service is excellent. But this doesn't diminish concerns that if payments are cut too sharply, that access problems could arise.

And I am concerned about our ability to recognize in an objective fashion that we have an access problem is less than would be desired. What we are going to find is that if we have access problems, they are not going to be uniform, national problems; they will probably be focused for certain services and certain localities, which means they are going to be more difficult to find.

We are going to have to use a whole array of indicators in defining certain procedures where, for example, we don't have concern that these procedures are overprovided and that these procedures could be monitored carefully as indicators of access.

As I say, I think the data lag will shorten, but we should not assume that we can just pursue any policy and have an ironclad guarantee that if something is cut too far, that we will find out right away.

There is a risk that it will take a long time to find out, and that we wouldn't find out about all the problems. I am sure you will have the frustration of being besieged by an increased volume of anecdotes and not be able to evaluate whether they are isolated instances or the biased perspective of someone, or reflect a more serious problem. Because this is something that no payer has ever tried to do before.

Mr. ROWLAND. Would you comment on the unintended reductions of the first year that the payment reform is in place—it was not realized, as I understand, that the increases that were intended by RBRVS would be skewed in the first year. Would you comment on that?

Mr. GINSBURG. Are you talking about the balance billing limits coming into effect the year before the fee schedule?

Mr. ROWLAND. Yes.

Mr. GINSBURG. I doubt that was intended, and the result, of course, is that you have cases where certain services that will be increased in payment substantially under the fee schedule, these are the services that Congress intended to increase, that before this happens in 1992, some physicians who were providing those services and charging substantial balanced bills to the patients, will

find their revenues for those services reduced, because the Medicare payments are the same and the revenue from balanced billing will be constrained by the 125 percent limits.

In general, that is something that the Congress always tries to avoid, of lowering someone's—in this case, not the payment, but someone's revenue the year before it is going to be increased when the policy comes into effect.

So, the Commission has done some simulations with its Medicare data base to see how substantial the problem is. We did not study just how many physicians will have their revenues reduced because of the balanced billing limit, but how many physicians will have their revenues reduced in 1991 only to have them restored in 1992. And that is what we tried to measure—how much will be an overshooting, how much of it will be restored in 1992?

We found that the pattern in primary care and in rural areas was most pronounced. Overall, nationally, and even in some of these areas, the amounts per physician didn't seem to be extremely large, and the number of physicians affected in a substantial way is not large, but the problem is definitely there.

Mr. ROWLAND. I have a largely rural area and primary care physicians, and that was my particular interest in that. I see my time—let me just ask you: What measures or what steps are being taken to try to neutralize or put some equity into that?

Mr. GINSBURG. There are two possibilities. One would be to revise the balanced billing limit for 1991. One could have a very narrow relaxation, for example, just focusing on primary care services—and also relaxing it only to the extent that you avoid this reduction that will be restored by an increase. Or you could have a more general relaxation.

The Commission feels that it wouldn't be wise to reopen the issue of balanced billing policy at the moment, and it has proposed an alternative of raising the floor on Medicare payments for primary care that was established by OBRA 87. The floor currently is 50 percent the national average, and the commission suggests raising this to 65 or 75 percent of the national average.

We have seen some analyses that suggested that would make a substantial dent in the problem. This is what the Commission is supporting.

Mr. ROWLAND. Thank you very much.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mrs. Collins.

Mrs. COLLINS. Thank you, Mr. Chairman. I am sorry I wasn't here when opening statements were given.

Let me point out my great concern with the possibility of reducing Medicare overlays. One reason I am so concerned, because in my district in Chicago, we have a very large number of senior citizens.

As a matter of fact, I think it is fair to say in that district, we have more senior citizens' buildings than perhaps any other district in the city itself. So it is going to impair very severely on their health and well-being as a whole.

I want to also take the opportunity to welcome Dr. Robert E. McAfee and Dr. Paul Ebert to our hearing today. They are both

going to be our witnesses, and they are also from the city of Chicago, and we are certainly glad to hear them.

Although I will not be able to hear their testimony, I am taking it with me, because I have to go to the full committee chairman's oversight and investigations hearing right now, as a matter of fact, and won't be able to hear what they have to say as they become part of the third panel.

However, if I have an opportunity, I will be coming back. With that, Mr. Chairman, I yield back the balance of my time.

Mr. WAXMAN. Thank you very much. Since you have the time, will you yield?

Mrs. COLLINS. I will be happy to yield to the Chair.

Mr. WAXMAN. Let me see if I understand something that seems a little bit new in this debate. It used to be we would think about reducing the amount paid for services to physicians, and we would save money.

Now there is a recognition that when we reduce the fee for services, that many physicians have the opportunity—not just the opportunity, but they will, in fact, make up the difference by providing more services to more people or more services to the patients they have.

So, the CBO and HCFA, for the first time, are arguing we don't just save money, we end up—it ends up costing us money. So that we cut payments for the service—cuts which don't really save us the amount that we are going to deduct, only half of that amount.

Is that the theory?

Mr. GINSBURG. That is right.

Mr. WAXMAN. Now, we have also said that we are concerned about the increase in volume. So that we have now in the law a provision saying that if the volume is increasing, we are going to do something about it. Down the road, we are going to then reduce the payment of physicians even more.

Now, presumably, if you do that to make up for the extra increases in volume, wouldn't that increase the volume even more? Aren't we sort of giving all the wrong incentives in this kind of structure?

Mr. GINSBURG. It is difficult when you think of the implications of this assumption, they get particularly peculiar. One thing that occurred to me just now is that we have been talking a lot about the effect of reducing Medicare fees on access to care by the Medicare population.

But this assumption suggests that access will improve when fees are reduced. Physicians will look for more things to do for Medicare patients because their fees are lower. And I think——

Mr. WAXMAN. How about the quality? We don't even know, do we?

Mr. GINSBURG. We don't have an assumption about that. It seems—this really brings up the point. Clearly, if you think longer term, if Medicare fees were reduced substantially, I don't think anyone would argue that access might be a problem.

So this assumption of 50 percent really isn't relevant for the long term. And the problem is if we use the assumption every year to—for our short-term policies, we can be misled, because eventually we will be in the long run now for the changes we made in 1984.

Mr. WAXMAN. We are operating very much in the dark on the basis of assumptions that may be absolutely incorrect. And one of the assumptions last year in the physician payment reform proposal which I was very troubled by was the idea that we should put some kind of constraint over all the volume increases and then reduce future years of payments to physicians for services, as if we knew that we are going to deal with the original problem.

We have no idea that is going to be the result.

Mr. GINSBURG. We have seen a lot of evidence so far of very serious activity on the part of the physician community to take steps to increase information to physicians about appropriateness.

Mr. WAXMAN. Until we do things like that, until we increase more information about appropriateness, have the outcome research recommendations on the kind of practice that physicians ought to be providing, we are not really talking about anything that is specific enough or sensitive enough to accomplish what we want to accomplish.

In other words, it is a meat ax approach.

Mr. GINSBURG. It is an approach of a broad incentive to the medical profession. I would not characterize it as a meat ax, because the policy, when it is implemented properly, permits us to see what happens before the—the one tool that we have to control outlays, which is affecting fees, is used. This has to be an improvement over not attempting to do this and just reducing the fees, which is the only other tool that can be scored in the budget process.

Mr. WAXMAN. Do you think we ought to think that CBO and HCFA are correct in their new assumption that when we depress fees, we are increasing service and therefore, we have to figure we don't save as much?

Mr. GINSBURG. I don't think it is correct, and it is very troubling to me. The basic implication of it is that if you are given a particular target to reduce Medicare physician outlays and you have this assumption, it means you have to cut fees twice as far to achieve that target than you would have had with a different assumption.

So, it is really a crucial assumption, and it really doesn't have much basis.

Mr. WAXMAN. What is the basis for this new assumption they are making? Is it based on data that has been received and evaluated, or is it based on a new theory?

Mr. GINSBURG. There is some data that has been analyzed, and it is fragmentary. Actually, this assumption has been used in some forms for some time. The commission has focused attention on it, but it is not a new thing. It was done in the previous bills, but perhaps it has not been as important as this year, because we have never faced the potential—as large a savings target as this year. It is not that they have ignored other evidence that would show the opposite, it is just that—and as researchers, I can understand how they have come to some of the conclusions.

I just think they have used it in a way that suggests a lot more confidence than most people have in those estimates.

Mr. WAXMAN. And then, I asked you earlier if we work on the assumption that depressing the fees will not have the complete impact of saving the dollars, increasing fees may produce—less of an increase in volume that otherwise might be expected.

So that ought to be factored in as well.

Mr. GINSBURG. Yes. I have seen no evidence or very limited evidence to lead us to use anything other than a symmetric assumption, that whatever assumption we use for fee decreases, we ought to use for fee increases.

And this will be very crucial to the setting of the initial conversion factor next year, because we have lots of fee increases and lots of fee decreases, and if you assume you have a volume of response to fee decreases and none to the fee increases, you wind up with a sharply lower conversion factor than certainly we would have anticipated.

There is an enormous amount at stake in the decision of how to set the conversion factor to fulfill the legislative requirement that it be budget-neutral. A symmetric assumption can result in a very sharp reduction of fees overall.

Mr. WAXMAN. If my colleagues would permit one other question—and I know my time has expired. We work on an assumption from year to year. We work on the estimate. We expect Medicare to be going up, and when we make changes, we are scoring it to not go up as much, as we reduce the budget deficit, presumably.

Yet the—do we know whether those assumptions in the past years have been accurate? Have we actually reduced the Medicare increases from what they otherwise would have been? Can we have any comfort from past experience that we really accomplished what we set out to accomplish, or is it possible in doing all this that we aided the increase in inflation in health care costs, which only increases the amount of the assumption of growth for the next year, and how much we have to reduce to get some savings?

Mr. GINSBURG. I believe CBO recently came out with some analysis looking back over many years of budget cuts. I cannot recite its conclusions precisely, but I believe that if you just look at the physician payments, the fact that the trend in the increase in the volume of services has continued at about 6 percent per beneficiary per year in the late 1980's, similar to the way it was in the early 1980's, before physician payment began to be cut.

This seems to be at least crude evidence of the fact that the budget cuts probably have saved money, and have not been substantially offset by increases in the volume of services induced by it. But overall, it is very difficult to go back and measure the effect of budget cuts, because there are so many other things changing in the medical system that have nothing to do with the budget cuts, and the task is to try to identify which changes were in response to the budget cuts.

It is certainly an important activity that ought to be done routinely.

Mr. WAXMAN. We do it routinely.

Dr. Rowland.

Mr. ROWLAND. Mr. Chairman, you certainly focused on some interesting consequences of the volume trend that we have had in recent years, and in trying to deal with payment in Medicare. And it seems to me that it has certainly been contradictory, what has been taking place, not what was intended to take place.

Then you mentioned the word Mr. Ginsburg said he really couldn't answer, and that is quality of care. You are not really able

to assess quality of care, which seems to me is one of the most important things that we need to be thinking about. It is really disconcerting when one thinks about what we have been doing over the past several years in order to deal with some of the problems in the Medicare health delivery program, and it has not been doing what we thought it would do.

What do you see as the long-run, strategic direction we are taking and the ultimate end to where we are headed?

Mr. GINSBURG. As far as limitation of costs, our main long-run hope is the outcome's research, getting the results into physicians' hands and in ways they will pay attention to it, to practice in accordance with this research.

In addition, the issue of physician supply is something that has to be looked at as far as our long-run goals of cost containment. The evidence is quite strong that when you have more physicians, you will have more expenditures. That has been a major factor in the increase in medical costs over time. We need to pay attention to the specialty mix of physicians as well as the aggregate number of physicians.

Our country is not unique in having a rapidly growing physician supply, and apparently having that drives costs higher.

Mr. ROWLAND. Do you think that what we have been doing over the years in trying to deal with these problems encourage gaming of the system by providers?

Mr. GINSBURG. My personal view is that a provider who is going to game the system will do so whether we have changed the structure of payment or not. If you talk to economists about this, they will say if someone is willing to—is interested in gaming the system, they will do it, whether they pay $90 or $100 for that procedure. However, I have heard oftentimes people speak of the fact if physicians feel they are treated fairly, they will be much less likely to game the system.

It is a difficult thing to research this issue, but I do believe in that partly. It is important probably for gaming, as well as for many other reasons, as we proceed with payment reform, I think as we have done, that we make sure that we have a lot of input from physicians, and that the system is credible to them.

Mr. ROWLAND. I think that is most important. I feel that if physicians or providers in general are treated fairly, they won't try to game the system. I look at that kind of like I do the IRS, Internal Revenue Service. I think if people feel they are being treated fairly, they won't try to game it, but if they don't, they will try to game it and get around paying taxes.

I thank you, Mr. Chairman.

Mr. WAXMAN. Any other member wish to ask further questions?

We very much appreciate what you have to say, and as we look at whatever the summit has come up with on Medicare reductions, we will want to consult with you further.

Our next two witnesses bring the perspective of Medicare beneficiaries to the subcommittee. As we consider all the issues before us, I know our members are particularly interested in the experiences and recommendations of these organizations which have been most helpful to us in the past.

Marsha Simon is director of Public Policy for Families USA, a seniors advocacy organization with a special interest in the low-income elderly. Joining Ms. Simon on the panel is Margaret Dixon, a member of the board of directors of the American Association of Retired Persons. AARP includes in its membership a substantial number of Medicare beneficiaries.

I am pleased to welcome the two of you to our hearing. Good morning. Your prepared statements will be in the record in full. We would like you to limit your oral presentation to no more than 5 minutes.

Ms. Simon.

STATEMENTS OF MARSHA SIMON, LEGISLATIVE DIRECTOR, FAMILIES USA; AND MARGARET DIXON, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. SIMON. Thank you, Mr. Chairman, for the opportunity to present our views here today on the effect of proposed cuts in the Medicare program on beneficiaries, particularly those who are poor and near poor, of proposed cuts in the Medicare program.

Proposals before the Congress will create severe financial hardship for low-income seniors. These proposals include suspending or delaying the balanced billing limits enacted as part of physician payment reform last year, and other proposals are discussed in our written testimony.

Physician payment reform was passed as a three-legged stool with three equally important and related parts: The new physician fee schedule to make more equitable Medicare payments to physicians; the volume performance standard to control physician costs to the Federal Government; and beneficiary improvements, including balanced billing limits to make part B more equitable for beneficiaries as well. Now, some physician groups are looking for the opportunity to jettison the beneficiary protection leg of the three-legged stool.

In this first year after enactment, it is crucially important that Congress demonstrate that it is committed to physician payment reform as enacted. We acknowledge, however, some physicians, particularly primary care providers, whose income will rise under the fee schedule, may lose income in 1991 due to the balanced billing limits.

The Physician Payment Review Commission recommends increasing the primary care floor up to 75 percent of the national average prevailing charge. The approach recommended by the PPRC is, we believe, the appropriate solution to the problem. Perhaps it may be possible to make it a 1 year adjustment. It is our view a major goal of physician payment reform was to increase the fees Medicare pays for primary care, not to increase balanced bills to beneficiaries for primary care.

The administration and congressional leadership have agreed to discuss cuts in entitlements as part of the budget summit. Options from the Congressional Budget Office and others include a proposal to increase the amount of the part B premium so that it covers 30 percent of the program's cost by 1995; a proposal to increase the part B deductible to as much as $150 a year, indexed thereafter;

and a proposal to require beneficiaries to pay 20 percent of the Medicare payment for clinical laboratory services.

These changes will create serious financial hardships for many beneficiaries, especially the poor and near poor who do not get Medicaid benefits. Our preliminary analysis shows that increasing the part B premium to 30 percent of program costs by 1995 and increasing the deductible to $150 in 1991 and subsequently increasing it by program costs will cost beneficiaries 20 percent more in 1995 than a 1 year freeze in their Social Security COLA.

The part B premium increase alone has exactly the same dollar impact as a 1 year freeze in the COLA. Of the money raised by increasing the part B premium and deductible, approximately 53 percent comes from seniors with income below $20,000; approximately 32 percent from seniors with income between $20,000 and $40,000; for a total of 85 percent from seniors with income below $40,000.

Theoretically, there are two means by which low-income beneficiaries are protected from increases in part B costs: The Medicare buyin and the Social Security hold harmless. The Medicare buyin requires State Medicaid programs to pay Medicare cost-sharing for beneficiaries with incomes under 95 percent of poverty in 1991 and under 100 percent of poverty in 1992. There is no buyin protection for those with incomes above the poverty guideline. Furthermore, a large number of those entitled to buyin protection are not receiving it.

As of 1986, only approximately one-third of poor seniors received Medicaid benefits. Preliminary data indicate that the participation rate in the buyin has been very low as well. As of July 1989, according to a study by Diane Rowland, and others, only 54,000 seniors not previously eligible to receive Medicaid were receiving buyin protection enacted in catastrophic.

Currently, Medicare beneficiaries are "protected" from part B premium increases which are greater than their Social Security COLA's. This hold harmless does not prevent low-income seniors from completely losing their Social Security COLA's to part B premium increases and, therefore, suffering losses in real income.

In summary, these proposals have serious financial consequences and there are no adequate protections in current law for low-income beneficiaries. We urge the Congress to reject these proposals.

Thank you.

[Testimony resumes on p. 39.]

[The prepared statement of Ms. Simon follows:]

Testimony by

Marsha Simon
Legislative Director

Families USA

Thank you, Mr. Chairman for the opportunity to present our views here today on the effect of proposed cuts in the Medicare program on beneficiaries, particularly those who are poor and near poor. I am Marsha Simon, Legislative Director of Families United for Senior Action (Families USA).

Proposals before the Congress will create severe financial hardship for low income seniors. Specifically, these proposals are: modifications in the physician payment reforms enacted last year; increases in the Medicare Part B premium and deductible; and a requirement that beneficiaries pay 20 percent of the Medicare fee for clinical laboratory services.

BENEFICIARY PROTECTIONS IN PHYSICIAN PAYMENT REFORM

The physician payment reform package enacted by Congress last year included several reforms particularly important to Medicare beneficiaries. Advocates, the Physician Payment Review Commission and the Congress supported these reforms as an integral part of a package balanced to meet the needs of physicians, beneficiaries, and the federal government.

Medicare Physician Payment reform was passed as a three-legged stool with three equally important and related parts: the new physician fee schedule to make more equitable Medicare payments to physicians; the volume performance standard to control physician costs to the federal government; and

beneficiary improvements, including balanced billing limits to make Part B more equitable for beneficiaries as well.

Now, some physician groups are looking for the opportunity to jettison the beneficiary protection leg of the three-legged stool. Congress should reject these efforts to undermine a package of reforms designed to achieve all of these important goals.

Beneficiaries supported adoption of the fee schedule, hoping that increased fees for primary care and rural physicians will improve beneficiaries' access to those physicians. At the same time, beneficiaries were adamant that they should not be liable for additional balance billing from physicians whose fees would be reduced under the fee schedule. Without balance billing limits, the Physician Payment Review Commission estimated that beneficiaries would face a 32 percent increase in balance billing liability.

Since the fee schedule ensures physicians fair and rational Medicare fees, limits on balance billing are the appropriate way to protect beneficiaries from having to pay out-of-pocket for physician payment reform. The limits are scheduled to begin in 1991, to prevent physicians from increased balance billing in anticipation of the fee schedule.

Some physicians, particularly primary care providers, whose income will rise under the fee schedule, may lose income in 1991 due to the balanced billing limits. The Physician Payment Review Commission recommends increasing the geographic floor for primary care to 75 percent of the national average prevailing charge. Such an adjustment will offset reductions in practice revenue that could result from applying the balance billing limit before increases due to the fee schedule have taken effect.

The PPRC recommends this approach over the approach advocated by some physician groups -- postponing implementation of the balance billing limits. According to the Physician Payment Review Commission, the physician groups' proposal allows physicians to increase beneficiaries balance bills by a dollar for every additional dollar physicians receive from Medicare. A major goal of physician payment reform was to increase the fees Medicare pays for primary care, not to increase balance bills to beneficiaries for primary care.

The approach recommended by the PPRC is the appropriate solution to problem. Consistent with the goals of physician payment reform, primary care physicians should receive their update, with special adjustments for primary care physicians in areas with low prevailing charges. In fact, it may be possible to make a one-year, special supplemental payment to primary care physicians with low charges.

Suspending or delaying balance billing limits is a very dangerous proposal. It is too broad a fix for the identified problem and it would unravel of the carefully balanced packages you were so instrumental in passing just last year. In general, internists and other physicians in lower income specialties balance bill less than physicians in higher income specialties. In addition, proportionately there is not a lot of balance billing for office care. The evidence on current balance billing practices suggests that primary care physicians, who are currently subject to low Medicare fees, do not make up for these low fees through significant balance billing. For this reason, a liberalization of the limits enacted last year would not address the one-year problem faced by these physicians.

The American Medical Association and some other physician groups have always opposed any limits on what doctors can charge. In Massachusetts, the first state to prohibit balance billing under Medicare, the medical society has tried every year to get the legislature to repeal the prohibition. Last year, some physician groups focussed their attention on weakening the volume controls included in the physician payment reform package. This year, these groups are back trying to undermine the physician payment reform limits on balance billing.

In this first year after enactment, it is crucially important that Congress demonstrate that it is committed to

physician payment reform as enacted. This means that the Congress should move towards the restructuring of Medicare fees and that beneficiaries should not be subject to increased out-of-pocket costs as a result of that process.

PHYSICIAN SUBMISSION OF CLAIMS

The Physician payment reform as enacted, provided Medicare beneficiaries with relief from filing Medicare claim forms. The PPRC recommended and Congress included this change in the physician payment reform package for two important reasons. First, beneficiaries find filing the claims confusing and burdensome and sometimes even fail to seek the reimbursement that is due to them or fail to file accurate or timely claims. Secondly, it is important to ensure that the Medicare program has the most accurate data possible on services provided to beneficiaries. Physicians are prohibited from charging beneficiaries for filing Medicare claims.

Now, the Administration is proposing that physicians be required to pay a one dollar charge for each paper claim that they submit to Medicare. And, Representative Kolter has, with the AMA's support, introduced legislation, H.R. 4772, to repeal the requirement that physicians submit all Medicare claims.

Both proposals undermine a very significant Medicare reform for beneficiaries. According to the AMA, over 95 percent of

claims are already filed by physicians. We urge you to maintain the requirement, and to reject the Administration's proposal to charge physicians for filing claims.

DEFICIT REDUCTION PROPOSALS

The Administration and Congressional leadership have agreed to discuss cuts in entitlements as part of the budget summit. Options from the Congressional Budget Office and others include a proposal to increase the amount of the Part B premium so that it covers 30 percent of the program's cost by 1995; a proposal to increase the Part B deductible to as much as $150 a year (indexed thereafter); and a proposal to require beneficiaries to pay 20 percent of the Medicare payment for clinical laboratory services.

These changes will create serious financial hardships for many beneficiaries, especially the poor and near poor who do not get Medicaid benefits. Our preliminary analysis shows that increasing the Part B premium to 30 percent of program costs by 1995 and increasing the deductible to $150 in 1991 and subsequently increasing it by program costs will cost beneficiaries 20 percent more in 1995 than a one year freeze in their Social Security COLA. The Part B premium increase alone has exactly the same dollar impact as a one year freeze in the COLA.

Of the money raised by increasing the Part B premium and deductible, approximately 53 percent comes from seniors with income below $20,000; approximately 32 percent from seniors with income between $20,000 and $40,000; for a total of 85 percent from seniors with income below $40,000.

The proposal to require beneficiaries to pay 20 percent of the Medicare payment for laboratory services will also have a disproportionate impact on low income seniors. Forty-four percent of poor and 40 percent of near poor seniors report that they are in poor health, compared to 22 percent of elderly persons with moderate or high incomes. Those in poor health are undoubtedly more likely to need laboratory services -- the utilization of which is largely controlled by physicians, not beneficiaries. Moreover, costs for laboratory services are one of the fastest growing components of health care costs.

Proposals to increase Part B cost-sharing amount to significant increases that would be imposed regressively. Furthermore these increases would come on top of previous staggering increases in beneficiary costs for Part B. Over the last ten years, the Part B premium alone has increased by almost 300 percent -- about ten times the inflation rate which determines Social Security COLAs.

INADEQUATE PROTECTIONS FOR LOW INCOME SENIORS

Theoretically, there are two means by which low income beneficiaries are protected from increases in Part B costs: the Medicare buy-in and the Social Security hold harmless provision. In reality, both provide wholly inadequate financial protection for the 41 percent of seniors with incomes under 150 percent of poverty and the 55 percent of seniors with incomes under 200 percent of poverty.

The Medicare buy-in requires state Medicaid programs to pay Medicare cost-sharing for beneficiaries with incomes under 95 percent of poverty in 1991 and under 100 percent of poverty in 1992. There is no buy-in protection for those with incomes above the poverty guideline.

A large number of those entitled to buy-in protection are not receiving it. In order to get this protection, seniors have to go to local welfare offices and go through a cumbersome application process. Because the income eligibility level is being increased each year, seniors who were not eligible in one year may be eligible in a future year, but must reapply. The Health Care Financing Administration sent out a notice to potentially eligible beneficiaries in 1989, but has been unwilling to send out subsequent notices as the income eligibility level increases.

The participation rate of the elderly in Medicaid has been persistently low. As of 1986, only approximately one-third of poor seniors received Medicaid benefits. Preliminary data indicate that the participation rate in the buy-in has been very low as well. As of July 1989, according to a study by Diane Rowland, Alina Salganicoff and Barbara Lyons of Johns Hopkins University, only 54,000 seniors not previously eligible to receive Medicaid were receiving buy-in protection.

Those seniors who are receiving buy-in protection still face access problems that other Medicare beneficiaries do not. In a number of large states, including California, Michigan and New York, state Medicaid programs will not pay beneficiaries' 20 percent coinsurance if the Medicare payment is greater than or equal to what the state Medicaid program would have paid. This means that physicians in those states must agree to treat low income seniors for 80 percent of the fee that they get for other Medicare beneficiaries.

HOLD HARMLESS PROTECTION

In 1990, Medicare beneficiaries are "protected" from Part B premium increases which are greater than their Social Security COLAs. This hold harmless does not prevent low income seniors from completely losing their Social Security COLAs to Part B premium increases and, therefore, suffering losses in real income.

Under the proposals to increase the Part B premium and deductible, in 1995 approximately 85 percent of seniors would lose three-quarters or more of their Social Security COLA to the Part B increases. Thus, the current hold harmless provision provides no meaningful protection for low income Medicare beneficiaries.

Furthermore, the Administration 1991 Budget proposes that the Part B premium be set at a minimum of 25 percent of program costs. This proposal eliminates the hold harmless protection as well as repeals permanent law which stipulates that the Part B premium can increase by no more than the same percentage as the Social Security COLA. We oppose this further weakening of already inadequate protections.

CONCLUSION

Proposals before the Congress to increase balance billing limits and to increase beneficiary costs for Part B will create extreme financial hardships for low income Medicare beneficiaries. Prior to these increases the 41 percent of seniors with incomes below 150 percent of poverty were spending in excess of 20 percent of their income, on average, on Medicare-related out-of-pocket spending. We urge the Congress to reject proposals that will create such serious financial hardship for economically vulnerable seniors.

Mr. WAXMAN. Ms. Dixon.

STATEMENT OF MARGARET DIXON

Ms. DIXON. Good morning.

My name is Margaret Dixon. I am a Member of the Board of Directors of the American Association of Retired Persons. I am pleased to be here today to share AARP's perspective on the proposed Medicare budget reductions.

Let me begin by saying that AARP commends you, Chairman Waxman, and your subcommittee for continuing efforts to protect Medicare and Medicaid so that all Americans have better access to health care.

I will focus my remarks on three areas: One, the need to bring the budget deficit under control; two, current out-of-pocket health care costs of Medicare beneficiaries; and, three, the effects of proposed budget reductions on older persons.

Mr. Chairman, AARP members feel very keenly the grave implications that this deficit has for our children and grandchildren. At the same time, we are concerned that if, in Congress' attempts to correct the deficit, we cut health and income protection, then we will have robbed Americans of the economic improvement that deficit reduction is intended to accomplish.

Older Americans recognize and accept their responsibility to share in deficit reduction measures. But they must not be asked to carry a disproportionate share of the load.

Before proceeding to discuss Medicare, I do want to say that AARP is aware that Social Security is viewed as a source of deficit reduction by some in Congress. We believe that this view ignores a key issue: Namely, that Social Security does not contribute to the budget deficit. Proposals to cut benefits by reducing COLA's or increasing the taxation of benefits fail to recognize that any money "saved" would not be applied to deficit reduction but simply add to the growth in the Social Security reserve.

Moreover, even a 3-month COLA freeze would push 125,000 persons below the poverty line.

AARP believes that fairness in deficit reduction should also apply to the Medicare program. Medicare was intended to protect older and disabled Americans against the cost of care. It has not been completely successful in this respect.

Beneficiaries now spend about 15 percent of yearly income on health care, the same as was spent before Medicare was enacted. In 1988 alone, a beneficiary's average annual out-of-pocket costs for covered part B services totaled $756.

The direct burden of the cost of medical care falls most heavily on older and poorer beneficiaries. For example, Medicare pays for only 35 percent of total health expenditures of people age 85 or older. And these are the persons least likely to be able to afford medigap protection. Furthermore, high medical expenses do not automatically ensure Medicaid eligibility.

It has been reported that Members of Congress and the administration are now considering several budget reduction proposals which would directly affect Medicare beneficiaries. AARP has ex-

amined raising the part B premium and/or deductible in several different scenarios.

Our analyses reveal that cuts in Medicare invariably fall most heavily on lower income beneficiaries. For example, in the part B premium is raised to 30 percent of program cost starting in 1991, the deductible is increased to $150, but the Social Security COLA remains unchanged, then nearly 26 million aged persons would be adversely affected.

The burden on near poor enrollees is more than twice as great as on higher income enrollees.

In another scenario, if a 3-month freeze on the COLA is imposed, the part B deductible is set at $100 and the premium is raised to 26 percent of program costs in 1991, rising to 30 percent by 1995, then, as in the first scenario, the burden on the near poor is more than twice as great as on the average income. Nearly 29 million enrollees would be affected by this, about 2 million more than affected by the first scenario.

AARP strongly urges that if any of these or similar measures are adopted, then protection of qualified Medicare beneficiaries, QMBS, should be expanded to a larger segment of the lower income Medicare population.

Let me conclude by saying that AARP continues to believe that deficit reduction must be one of the Nation's highest priorities, and we support a plan that is equitable, fair and effective.

One final note: In considering deficit reduction measures, the size of the first year's reduction is not as important as the trend line over several years. Achieving $50 billion in reductions is not magical; what is important is the mix of spending and revenue and the trend line over several years.

With this in mind, AARP will continue to work with Congress to find methods of deficit reduction which are equitable, fair and effective.

Thank you.

[The prepared statement of Ms. Dixon follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

Introduction

Good Morning. My name is Margaret Dixon. I am a member of the Board of Directors of the American Association of Retired Persons. I am pleased to be here today to share AARP's views on proposed Medicare budget reductions on older Americans.

Let me begin by saying that AARP commends you, Chairman Waxman, and your colleagues on this Subcommittee for your continuing efforts to protect the Medicare and Medicaid programs so that older persons may have better access to health care.

I will focus my remarks this morning on three areas: 1) the need for bringing the federal budget deficit under control; 2) the current status of Medicare beneficiaries--specifically, their current out-of-pocket costs for health care; and 3) how proposed Medicare budget reductions could affect older persons.

The Need for Deficit Reduction

Our country's ability to meet its human needs and create a better quality of life for its citizens is dependent on the continued health of our economy. That health is now somewhat uncertain as the most prolonged peacetime expansion in U.S. history slows almost to a stall.

The very real achievements of economic expansion--eight years of growth, relatively low unemployment and inflation rates, and a robust stock market--rest on an eroding foundation. The U.S. is now the world's largest debtor nation; our savings and investment rank near the bottom of developed nations; and our standard of living has been stagnant since 1973.

Annual federal deficits in the $150-$200 billion range have resulted in a tripling of our public debt since 1980. AARP members are keenly aware of and are concerned about the federal budget deficit and the grave implications it has for future generations.

Addressing the deficit poses a challenge. Continuing deficits threaten economic stability and the well-being of individuals whose income does not keep pace with the costs of goods and services, particularly health care services. The accumulated debt that is passed to future generations poses a risk to our grandchildren and great grandchildren. However, by cutting

domestic spending, programs of vital concern to all Americans--young and old--are put at risk. And, if in correcting the deficit we make cuts in benefits that substantially diminish the health and income protection enjoyed by many Americans, then we will have robbed them of the economic improvements that deficit reduction is intended to accomplish. There is also the concern that deficit reduction measures not inadvertantly undo some of the very measures--such as physician payment reform and the balance billing limitations for beneficiaries--which Congress enacted to keep health care costs under control.

Some progress has been made in reducing the deficit from its 1986 peak of $221 billion. However, much of this improvement is due to the rapid growth in Social Security revenues. If Social Security is removed from the calculation, the deficit is projected to grow to $241 billion by 1994. At current growth rates, every five years we will shift over a trillion dollars in debt to generations that will have many fewer taxpayers than today's. This trend must be reversed before irreparable damage is done.

While the deficit, expressed in dollar terms, remains alarming, it should be noted that as a percent of GNP the deficit has and is continuing to decline. In 1985, the deficit was 5.4 percent of GNP. By 1989, it had dropped to 3 percent of GNP and is projected to drop further in the next several years barring a recession. Many economists have concluded that deficits in the range of 2-3 percent of GNP are not inconsistent with long-term economic growth, provided the funds are used appropriately to strengthen our human and physical resources.

AARP believes that the federal government must move toward a more responsible fiscal balance. To accomplish this fairly, the responsibility for reducing the deficit must be shared across society, both through revenue increases and spending restraint. If the sacrifice in a package is fairly distributed, we understand that older Americans cannot be completely excluded from deficit reduction measures - nor should they be.

Social Security

While not the subject of today's hearing or this Committee's jurisdiction, AARP is aware that Social Security is viewed as a source of deficit reduction by some in Congress. The Association believes that this view ignores certain key issues. First, Social Security is not contributing to the federal deficit. In fact, the rapid growth in the Social Security reserves is masking the size of the deficit in the rest of the budget.

Proposals to cut benefits through a reduction in the Cost-of-Living Adjustments (COLA) or to increase the taxation of Social Security benefits do not recognize that any money "saved" would simply add to the growth in the Social Security reserve. By continuing down this path, we perpetuate the myth that Social Security reserves can actually reduce the deficit over the long term and increase the long-term threat to Social Security.

Further, either cuts in COLAs or increases in taxation take away income for which there may be no replacement for older Americans. For example, even a three-month freeze in the COLA would mean a permanent cut in lifetime benefits and would push 125,000 persons below the poverty line. Any longer-term cut in benefits would certainly have an even more devastating effect on vulnerable older persons.

Health Care Costs for Older Americans

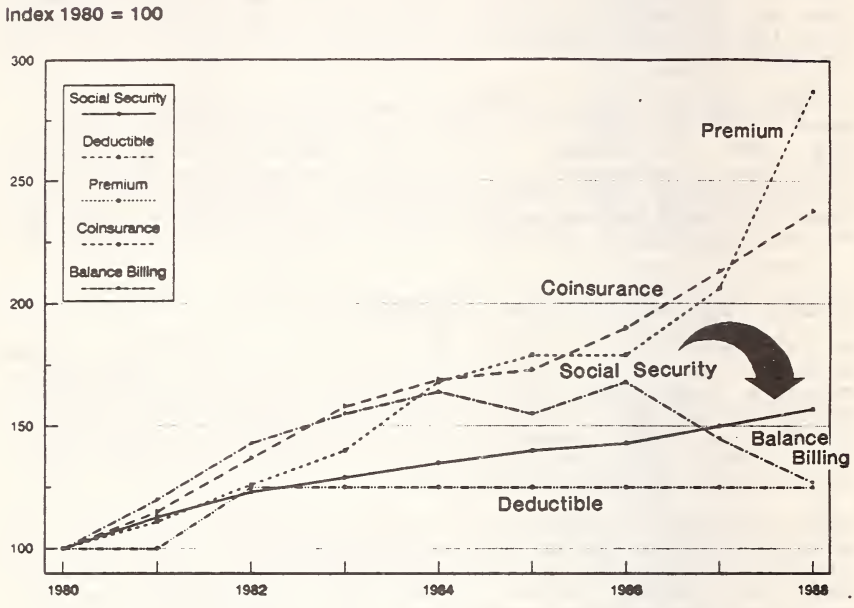
As the cornerstone of health care coverage for older Americans, Medicare has provided older persons with access to health care coverage since 1965. Rising health care costs have resulted in beneficiaries paying more for their health care needs in the intervening years. Beneficiaries now spend about 15 percent of their yearly income on health care - the same percentage they spent before Medicare was enacted.

While Medicare was intended to increase access to care and provide financial protection against the cost of that care, the program has been less successful in achieving the latter. Rapid and sustained growth in the cost of the program, as well as legislative changes resulting in cost-shifting to beneficiaries, have led to sharp increases in direct costs to beneficiaries.

Average per capita direct costs for Medicare Supplemental Medical Insurance (SMI) services (including premiums, deductibles and coinsurance) increased by about 140 percent between 1982 and 1989. The share of out-of-pocket costs attributable to the Part B premium has risen most rapidly over this period and now accounts for half of the total liability for covered physician services. Average annual out-of-pocket costs (i.e. premiums, deductibles, coinsurance and balance billing) per beneficiary for covered Part B services in 1988 totaled $756.

In current 1990 dollars, CBO estimates that annual average enrollee costs under Medicare rose more than twice as fast as enrollee per capita income between 1975 and 1990. (See attached chart). Yet, these averages, as striking as they may be, mask important variations in the distribution of costs among beneficiaries. The direct burden of the cost of medical care falls most heavily on older, sicker and poorer

Figure 1-5. Trends in Social Security Benefits and Part B Out-Of-Pocket Costs, 1980 - 1988



Source: Congressional Budget Office and Health Care Financing Administration.

beneficiaries. For example, Medicare pays for only 35 percent of total health expenditures (including long term care costs) of people age 85 and older. And HCFA estimates that out-of-pocket medical expense as a percentage of income is six times greater for near-poor aged (those with incomes at or below 125 percent of poverty) than for those with middle incomes.

In 1987, 70 percent of the non-institutionalized elderly purchased Medigap policies which insulate enrollees from cost-sharing requirements at the point of service. But 21.5 percent of the elderly had only Medicare coverage in 1987. The oldest and sickest enrollees are the least likely to have Medigap insurance. Furthermore, high medical expenses as a percent of income do not automatically ensure eligibility for Medicaid.

Previous actions by Congress to slow the growth rate of Medicare costs resulted in substantial cost shifts to beneficiaries. The GAO, in a 1988 report, concluded that the average inflation-adjusted out-of-pocket costs per Medicare enrollee for Medicare-covered services increased between 1980 and 1986 by about 73 percent for Part A services and about 36 percent for Part B services.

As Congress considers further deficit reduction measures, fairness warrants that those who have already borne the burden of previous deficit reduction efforts--particularly those least able to--should not be singled out to carry a disproportionate load.

Administration's Budget Recommendations

The President's budget proposal called for over $5 billion dollars in Medicare reductions. While the bulk of these reductions would be targeted at providers--both physicians and hospitals--it includes one recommendation which directly affects Medicare beneficiaries.

The President's budget proposed to continue the twenty-five percent premium floor for Medicare Part B program costs. Currently, the premiums Medicare beneficiaries pay for Part B services cover twenty-five percent of the program costs. In 1991, this will change, and any increases in the Part B premium will instead be limited by the amount of increase in the Social Security COLA. If--as in the President's budget--the twenty-five percent floor is continued, beneficiaries' out-of-pocket expenses will increase because health care costs continue to increase at rates that far exceed increases in the Social Security COLA. In addition, for low-income beneficiaries who are not eligible for Medicaid or the low-income buy-in protection, the increased costs will present an additional burden.

Budget Summit Recommendations

In addition to the President's recommendations, Congress is currently considering several budget reduction proposals, many of which would directly affect Medicare beneficiaries. AARP has examined several options--reported to be under consideration--such as raising and indexing the Part B premium and the Part B deductible, both separately and in combination. Our analyses reveal that cuts in Medicare invariably fall most heavily on enrollees with incomes between 100 and 150 percent of poverty. (It would also fall unevenly on those below poverty depending on whether they were enrolled in Medicaid or were Qualified Medicare Beneficiaries.)

For example, we looked at the effects of two scenarios, both of which take into account CBO's estimate of Part B provider savings generated by the President's proposal to reduce Part B costs.

The first scenario leaves the Social Security COLA in place but raises the Part B premium to 30 percent of program costs starting in 1991, and also introduces a flat, non-indexed $150 Part B deductible in that year. In this situation, the average increase in per capita enrollee cost in 1991 is $121 or 0.6% of family income. By 1995, the average per capita cost rises to $325 or 1.36 percent of income. However, for enrollees with incomes between 100 percent and 150 percent of poverty, these benefit cuts represent a greater burden, i.e., 1.52 percent of income in 1991, and 3.31 percent of income in 1995. In other words, the relative burden on near poor enrollees is more than twice as great as that on the average enrollee. Nearly 26 million aged persons will be adversely affected by these cuts.

In the second scenario, a three-month freeze on the COLA is imposed, as well as a flat, non-indexed $100 Part B deductible. In addition, the premium is raised to 26 percent of program costs in 1991, and rises to 30 percent by 1995. On average, this action will cost beneficiaries $119 or 0.57 percent of income in 1991. By 1995, however, the average per capita cost--$331, or 1.38 percent of family income--is greater than that under the first scenario. As in the first scenario, the burden on near-poor people is more than twice as great as the average cost. Nearly 29 million enrollees would be affected by the second scenario, about 1.7 million more than the number affected by the first scenario.

In light of these findings, we would strongly urge that if any options such as these are adopted as part of a budget reconciliation package, that Congress expand Qualified Medicare Beneficiary (QMB) protection to a larger group. It is imperative that the most vulnerable beneficiaries be protected from undue hardship.

Conclusion

Let me conclude by saying that AARP continues to believe that deficit reduction must be one of the nation's highest priorities and we support an approach that is equitable, fair, and effective.

* To be equitable the package Congress chooses must spread the pain. No one group or sector of the economy should be singled out to bear the brunt of cuts.

* Fairness also demands that any package protect those most vulnerable in our society and recognize sacrifices made by various groups in this and previous budget reduction efforts. In this respect, any deficit reduction measure that affects lower income beneficiaries must also expand protection for these individuals through an improved QMB program.

* Effectiveness in reducing the deficit requires that attention be directed to the need to restore the revenue base to a fiscally prudent level and that defense spending and mounting costs of the financial industry rescue continue to be subjected to close scrutiny. In health care, where the costs of goods and services outstrip those in most other sectors of the economy, effectiveness depends upon continued efforts to put into place carefully constructed payment reforms that reduce costs but not access to essential services.

One final note of caution is warranted. In considering deficit reduction measures, the size of the first year's reduction--though obviously having a bearing on future years--is not as important as the trend line over several years. Achieving $50 billion in deficit reduction in one year is extremely difficult and can tilt a deficit reduction package towards short term cuts that may not be wise from a longer term perspective. Moreover, the figure of $50 billion is not magical--what is important is the mix of spending and revenue and the trendline over several years. As noted above, the deficit is today declining as a percent of GNP. A realistic package of revenue increases and spending reductions can continue this trend without creating havoc on either the economy or individuals.

With this in mind, AARP will continue to work with Congress to find methods of deficit reduction which are equitable, fair and effective.

TSV-000820-726

Mr. WAXMAN. We need to recess to respond to the floor.

[Brief recess.]

Mr. WAXMAN. I want to thank both of you for your testimony. Let me pursue some questions, if I might.

Ms. Simon, you were urging us to reject several proposals of the administration that would increase the out-of-pocket health costs of the elderly, particularly the low-income elderly, without the protection of Medicaid or private supplemental insurance.

Has Families USA developed any recommendations that would increase the participation of those eligible for the Medicaid coverage of cost sharing under Medicare?

Ms. SIMON. Yes, we do have several proposals to improve participation. Our first would be to permit States to designate Social Security to do eligibility determinations for buyin benefits. It is our view that requiring QMB's to apply at social service or welfare offices is a deterrent to participation.

Mr. WAXMAN. How would the Social Security establish eligibility?

Ms. SIMON. The Social Security does, currently, eligibilities for people who qualify on the basis they are eligible for SSI, in 31 States, under so-called section 1634 agreements, so we believe that a large number of States would probably desire to designate Social Security to do that—those determinations, which they are already doing for the buyin operation as well.

In fact, when the buyin was first enacted, a number of States had asked that the administration, that they be permitted to expand their section 1634 agreements with the Social Security Administration to include the buyin population, and HCFA recommended that to the Social Security Administration, and it was not acceptable to Social Security.

Mr. WAXMAN. Why?

Ms. SIMON. I am not sure what their reason was.

Mr. WAXMAN. Even though they already do it in 30-some States?

Ms. SIMON. Well, in fact, at several points during the 1980's, the Social Security Administration indicated they would prefer to stop doing what they were already doing with respect to Medicaid determinations so it was consistent with that.

Mr. WAXMAN. Any other recommendations on how to deal with the low-income?

Ms. SIMON. We also think there needs to be more outreach. The only thing that has happened thus far is, last year, HCFA did a one-time-only notice to low-benefit Social Security beneficiaries of the availability of the buyin benefits.

We would like to see them do that annually—at least through the period while the eligibility limits are going up. I have had State people tell me they got a lot of calls from people who are not eligible yet, and it is important to bring those people back to the welfare offices.

There also needs to be outreach that goes on just providing notices to the beneficiaries. The Social Security Administration is undertaking a demonstration project on SSI, and it would be very good if that were expanded to the buyin.

Mr. WAXMAN. Do you believe we are in danger of adverse effects of accessibility of physician service to Medicare beneficiaries as a result of further payment reductions?

Ms. SIMON. I suppose at some point, it would be bound to have that effect, but I don't know, as Mr. Ginsburg, of any data that that has happened thus far.

Mr. WAXMAN. With regard to further cuts in payments for physician services as recommended in the President's budget, does Families USA take a position in favor of any or all of them?

Ms. SIMON. The beneficiary reductions?

Mr. WAXMAN. No, the cuts in payment for physician services.

Ms. SIMON. We would support the level of reductions provided in the House budget resolution.

Mr. WAXMAN. Dr. Dixon, I would be interested in any views of the AARP on what kind of payment reductions are appropriate, if any, for practitioner services under part B of Medicare. Any advice you would give us.

Ms. DIXON. AARP opposes any rollback in the balanced billing limits as they affect physician payments. However, we do recognize there might be some unique situation, such as rural physicians and primary care physicians, and AARP would be very willing to work with you on some solutions to target that population.

Mr. WAXMAN. Your statistics on the increase in health costs borne directly by Medicare beneficiaries is particularly distressing. I wonder if AARP could help us identify other approaches to limit increases in health costs that do not result in shifting costs to beneficiaries or create barriers to appropriate access?

Ms. DIXON. That is a very big problem. We realize it will take a lot of study and a lot of work by various segments in order to reach a satisfactory solution. We do not have any one answer to that at this point.

However, it is something we will continue to work on with the committee, and hopefully, we can come together to some satisfactory solutions.

Mr. WAXMAN. Do you have any recommendations on the income level for eligibility for the Medicaid buyin for Medicare out-of-pocket costs?

Ms. DIXON. We know there are certain levels, such as 100 percent of poverty level or 90 percent, 125 percent, but this doesn't give an accurate picture, because people have different levels of Medicare—of medical expenses.

So, it is hard to say one particular number. But we would like to see that all of the poor and near poor are able to afford health care, and I don't think we can put a number on it. Because various States have various levels, and there are some many provisions that have to enter into this.

But we do want to see people who are vulnerable able to get the health care they need.

Mr. WAXMAN. Dr. Rowland.

Mr. ROWLAND. Thank you.

Let me direct a question to both of you. How do you feel about means testing in the Medicare program or in Social Security, for that matter, which is already somewhat means testing?

Ms. DIXON. AARP feels Social Security is an entitlement program and means testing should not enter into it.

Mr. ROWLAND. Medicare—how do you feel about means testing in Medicare?

Ms. DIXON. We are not in favor of means testing.

Mr. ROWLAND. Let me ask you this: You were pointing out earlier some changes in deductible or copayments would affect the poor more than it would affect people who were in higher income brackets.

You don't feel people in higher income brackets, have a better income, should not bear more of the responsibility than people in lower income brackets?

Ms. DIXON. We would like to see a package that is fair and equitable for everyone. And we would have to look at an entire package to see what each segment is asked to bear and what each segment is asked to assume.

And if we see that fairness, we are in favor of it.

Mr. ROWLAND. I think everybody wants something fair and equitable. How we are going to get there, I guess that is the question. Are you opposed to means testing? AARP is opposed to means testing?

Ms. DIXON. Yes.

Ms. SIMON. We are opposed to means testing in the sense we are opposed to denying people access to the program's benefits based on income. We think the program should be there for everyone. We do not object to income sensitizing the program.

For example, we were one of the few groups throughout the catastrophic debate that supported the financing mechanism. We thought it was appropriate that the premiums reflect beneficiaries' ability to pay.

Mr. ROWLAND. Let me go back to AARP. I like that term, income sensitizing. How does the AARP feel about income sensitizing?

Ms. DIXON. I have to ask Ms. Simon what she means by income sensitizing.

Ms. SIMON. What I am suggesting is the cost-sharing might be different for different income groups, although the program would be broadly available to everyone without regard to income.

Ms. DIXON. Well, Ms. Simon mentioned catastrophic, and I would say that AARP was in favor of the benefits of catastrophic, but we were not entirely in favor of the financing.

Mr. ROWLAND. Let me ask you something we were pursuing earlier with Mr. Ginsburg, and there is anecdotal evidence that providers may be talking more and more about not participating in Medicare.

Do you hear very much anecdotal evidence, and do you have any objective evidence that is of concern to you in that respect?

Ms. DIXON. AARP does not have any evidence of this, at this time.

Ms. SIMON. We have no evidence that there is a problem of access for Medicare beneficiaries. There is evidence there are severe problems of access for that class of Medicare beneficiaries who also receive Medicaid, the buyin beneficiaries that we were discussing.

Mr. ROWLAND. You are not hearing from Medicare beneficiaries they are not able to get care or they don't have access to care, because of the fee structure that is in place?

Ms. SIMON. Not so long as Medicaid isn't one of the payers.

Mr. ROWLAND. Thank you, Mr. Chairman. Thank you.

Mr. WAXMAN. Thank you, Dr. Rowland.

I want to thank the two of you for your testimony. We look forward to working with you as we see what budget numbers we have before us.

The witnesses on our next panel represent a broad spectrum of practicing physicians of our country. These organizations have appeared frequently before our subcommittee. We look forward to their views on Medicare payment reform policies.

First we will hear from Dr. Robert E. McAfee, vice chairman of the board of trustees of the American Medical Association and a general surgeon in Portland, ME. He will be followed by Dr. Paul A. Ebert, director of the American College of Surgeons; and Dr. Nicholas E. Davies, president-elect of the American College of Physicians, and practicing internist at Piedmont Hospital in Atlanta, GA. Finally, we will hear from Dr. Donald Keith, a member of the board of directors of the American Academy of Family Physicians.

Let me thank you all for being here. Your prepared statements will be in the record in full. I would like to ask each of you to limit your oral presentation to no more than 5 minutes.

Why don't we start with Dr. McAfee.

STATEMENTS OF ROBERT E. McAFEE, VICE CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; PAUL A. EBERT, DIRECTOR, AMERICAN COLLEGE OF SURGEONS; NICHOLAS E. DAVIES, PRESIDENT-ELECT, AMERICAN COLLEGE OF PHYSICIANS; AND DONALD M. KEITH, MEMBER, BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Mr. MCAFEE. Thank you.

My name is Dr. Robert McAfee, I am a practicing general surgeon in Portland, ME, and vice chairman of the board of trustees of the American Medical Association. With me today is Ross Rubin of the AMA's division of legislative activities.

AMA is pleased to have this opportunity to testify by the budget summit to reduce up to $5.5 billion from the projected fiscal year 1991. AMA recognizes it is imperative that Congress work toward the goal of a balanced budget. We understand that in striving to reach that goal, this committee must make difficult decisions about how this goal will be achieved.

However, we cannot continue the practice of the past decade of massive budget-driven cuts and program changes in Medicare. Such cuts distort the program, and as I have discussed in my formal statement, the continuing changes of controls, sanctions, and other requirements are creating an atmosphere of mistrust and anger toward the program that concerns us very greatly.

These cumulative cuts have often been disordered, involving microadjustments to myriad aspects of the program, and have caused an annual rewrite of the complex Medicare rule book.

Most significantly, these cuts have indeed been very deep. Although Medicare outlays account for only 7 percent of the Federal budget, the Congressional Budget Office indicates cumulative budget savings in Medicare since 1980 account for 16 percent of total Federal budget savings, 7 percent and 16 percent.

Medicare has shouldered more than its share of budget savings. Just as total Medicare cuts have been disproportionately large, part B cuts in the last decade have been disproportionate in relation to total program spending.

Only last month, CBO released a report that counters the conventional wisdom that only part A of the program has taken significant cuts. The CBO confirms that we have long known as physicians, part B has absorbed disproportionate cuts, the report stated:

> On average over the 9 years from 1981 to 1989, the share of savings from the hospital inpatient sector was small relative to its share of spending, while the share of savings from the physician sector was disproportionately large.

Physicians and hospitals outlay departments account for a disproportionately large share of the overall savings, while savings from other service categories, this is, hospital inpatient, nursing and home health, are small in proportion to base disbursements for them.

Not only are additional part B cuts unwarranted, they would undermine the massive pay reform of OBRA 89. The resource base relative value system, and the Medicare volume performance standards, RBRVS, is the result of years of research and study.

The efforts of your committee, Mr. Chairman, and your leadership are well-known and appreciated by the profession in accomplishing this goal to date. We know this is designed to ameliorate the reimbursement inequities of the current reasonable charge system.

This as yet untested payment methodology, which will be phased in beginning 1992, is by law required to be implemented in a budget-neutral manner. Imposing further part B cuts in fiscal year 1991 will eviscerate the budget neutrality requirement by chipping away into payment levels in effect when Congress enacted the fee schedule.

Consequently, the fundamental goal of RBRVS with distribution resources will be subverted. There simply will not be adequate funds available to transfer from one specialty or geographic section to another.

Should this occur, individuals residing in underserved areas such as rural areas will likely remain underserved. Mr. Chairman, we also have strong concerns regarding additional items proposed by the administration in June. These proposals include an adoption of Medicaid prescription drug formularies with mandatory therapeutic substitution, and the establishment of a $1 charge for processing of nonelectronic claims.

The drug provisions which would radically change prescribing and dispensing practices for the Medicaid population are highly objectionable to us. The concept of therapeutic substitution is controversial and could severely impact on the quality of care available to the Medicaid population.

The $1 charge for processing each nonelectronic claim is yet another major problem. It is our understanding, if all physicians switch to electronic billing in 1991 to avoid the charge, Medicare carriers would not be able to administer all these claims. Therefore, this provisions amounts to nothing more than a tax on physicians.

I have addressed in my formal statement some of the other more problematic proposed budget cuts and some ancillary Medicare issues. We ask that you consider those points and the points I have discussed in your task of working toward a balanced budget.

We understand that no one wants to cut important programs. Medicare, and part B in particular, have taken disproportionately large cuts for many years. For the sake of Medicare beneficiaries, and their caregivers, we ask that you not perpetuate that unfairness by exacting additional cuts in fiscal year 1991.

If you determine, however, Mr. Chairman, that some savings must come from Medicare, we ask that you allocated the savings in proportion to respective part A and part B spending.

Thank you, Mr. Chairman.

[Testimony resumes on p. 73.]

[The prepared statement of Dr. McAfee follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

Presented by
Robert McAfee, MD

RE: Medicare and the Fiscal Year 1991 Budget Reconciliation

July 27, 1990

Mr. Chairman and Members of the Committee:

My name is Robert McAfee, MD. I am a practicing general surgeon in Portland, Maine, and Vice-Chairman of the Board of Trustees of the American Medical Association. With me today is Ross Rubin of the AMA's Division of Legislative Activities. The AMA is pleased to have this opportunity to testify regarding the very grave proposals currently being discussed by the Budget Summit to cut up to $5.5 billion from the projected Medicare budget for fiscal year 1991.

Mr. Chairman, the AMA recognizes that it is imperative that Congress work toward the goal of a balanced federal budget. We know that during the budget process over the last decade this Committee has made -- and will continue to make -- tough decisions about numerous programs. As you know, the Medicare program has presented the Congress with many difficult decisions over the years, and has suffered massive cuts since the inception and continued use of reconciliation during the '80s.

A decade of substantial budget cuts, including hundreds of yearly Medicare program changes, has created chaos among physicians and other providers, and into the next century will have long-term effects on patients, caregivers and our health care system. We are now feeling the impact of decisions made in the '70s concerning hospital and nursing home construction that have left major parts of our country with hospital and emergency systems near melt-down. If we continue this totally budget-driven decisionmaking with respect to physician services, we will guarantee the continued deterioration of Medicare.

THE IMPACT OF CUMULATIVE MEDICARE CUTS ON PHYSICIANS, BENEFICIARIES AND THE ENTIRE HEALTH CARE SYSTEM

The plight of physicians in today's budget-driven environment is aptly illustrated by the trilogy of articles published early this year in The New York Times. Bearing titles such as "Changes in Medicine Bring Pain to Healing Profession" and "Practice of Medicine is Undergoing Change, Demoralizing Doctors," the message is clear: physicians are reeling from the inordinate payment and practice changes of the 1980s. As one of the articles explained, the

> feeling of being shackled by rules and overseers is nearly universal among doctors today, experts inside and outside the profession say. Doctors say they are overwhelmed by paperwork, prohibited by insurance companies from doing procedures and subjected to scrutiny by group employers like health maintenance organizations that can even include scheduling of restroom breaks.

As a result of these factors, the practice of medicine as we have known it is diminishing. Physicians are abandoning self-employment for

salaried positions that spare them the burdens of start-up costs and office administration and the long hours associated with self-employment. This trend is especially disturbing for the underserved sector of the country, nearly three-fourths of which is rural.

Some physicians are forfeiting the practice of medicine altogether, and young Americans are rejecting medicine as a career choice. Medical school applications have decreased 25% over the past five years. Physicians' concerns about professional liability issues and six-figure liability premiums go unresolved, and Congress and HCFA rewrite the Medicare rule book every year.

As noted by Dr. William Roper (former Administrator of the Health Care Financing Administration, former Domestic Policy Advisor to the President and current Director of the Centers for Disease Control), the "growing disenchantment of the average doctor" is disturbing. To quote Dr. Roper, we should not treat doctors "as if we can abuse them and think we have lost nothing by it. I fear that the loss of faith by doctors will make them less caring and compassionate."

We are gratified that Representative Rowland, along with 188 co-sponsors, has introduced H.R. 4475, which addresses some of the administrative problems that have been causing physicians tremendous concern. A growing number of physicians are finding that the Medicare program, through budget-driven actions that have imposed burdensome administrative requirements, has over the past few years been virtually "redesigned." As Representative Rowland stated in introducing H.R. 4475, "more redtape - much of it unnecessary and sometimes even harmful - is the end result of a budget-driven system which substitutes short term economic paper gains for long-term sensible health policymaking." The

modifications contained in H.R. 4475 would include:

- Allowing release of screening information;
- Allowing flexibility in certain billing arrangements;
- Prohibiting charges for carrier-furnished information;
- Allowing medical society representation of physicians appealing Medicare payment decisions; and
- Establishing a practicing physician advisory council.

We believe that the administrative changes in H.R. 4475 -- which would cost the Medicare program no money -- would provide physicians with some positive relief from Medicare administrative "hassles," and we strongly support the bill.

What is the relevance of all this to the reconciliation process? It is the very relevant backdrop for your deliberations.

An additional relevant factor is the sweeping physician payment reforms of OBRA-89, which are predicted to produce major savings in the physician services sector of Medicare over the next 5 years. The Office of Management and Budget and the Congressional Budget Office (CBO) baselines are developed using projections that assume updates less than the Medicare Economic Index (MEI) update for the next five years, based on the use of default Medicare Volume Performance Standards (MVPS) and default conversion factors. Therefore, in this budget cycle, it is possible that physician services will not receive an increase adequate to cover increased practice costs.

The Administration's initially proposed fiscal year '91 savings and the additional cuts proposed in June, which come in the wake of the OBRA-89 payment reforms, are not a rational solution to the high costs of health care. The proposed savings are not the product of a reasoned and deliberative analysis of how to provide better and more efficient health care to the nation's elderly and disabled. Rather, they are the result of arbitrary attempts to find savings no matter how great the cost.

This short-sighted approach, which may produce some immediate savings, threatens to undermine the physician payment reforms of OBRA-89, jeopardize the availability of quality health care for Medicare beneficiaries and overwhelm the physician community that is attempting to practice medicine while accommodating the massive payment and practice reforms just adopted. In addition to the foregoing, we urge you to reject further cuts for the following three reasons.

I. MEDICARE HAS HISTORICALLY BEEN SUBJECTED TO A MASSIVE SHARE OF FEDERAL BUDGET CUTS

The Medicare program has been subjected to over a decade of major funding cuts through use of the reconciliation process. Although Medicare outlays account for approximately 7% of the federal budget, cumulative budget savings in Medicare since 1980 account for 16% of total federal budget savings, as illustrated by the following table.

FEDERAL BUDGET SAVINGS ESTIMATES ATTRIBUTABLE TO RECONCILIATION BILLS

Reconciliation Bill and Year	Impact Fiscal Year	Savings ($billions) Medicare	Total
OBRA '89	1990	$2.9	$9.0
	1991	1.7	4.2
OBRA '87	1988	2.1	8.8
	1989	3.8	7.0
	1990	3.9	3.9
OBRA '86	1987	-1.1	6.2
	1988	-0.6	-0.6
	1989	0.5	-0.6
COBRA '86	1986	0.5	6.0
	1987	1.6	6.9
	1988	2.3	7.3
DEFRA '84/OBRA '83[1]	1984	0.1	0.5
	1985	1.1	4.4
	1986	2.0	4.5
TEFRA '82/OBRA '82[2]	1983	2.8	6.8
	1984	4.3	10.4
	1985	5.8	12.7
OBRA '81	1982	1.5	35.2
	1983	1.1	44.0
	1984	1.3	51.4
ORA '80	1981	0.9	4.6
	1982-1985	1.4	16.5
TOTAL		$39.9	$249.1

Source: Estimates are from the Congressional Budget Office, Budget Analysis Division. Table prepared by AMA Center for Health Policy Research. Savings are estimates at the time of passage of reconciliation bills and have not been reestimated. Negative savings represent net deficit increases. [1]Total column includes OBRA '83, in which there were no Medicare savings. Medicare savings were in DEFRA only. [2]Total column includes OBRA '82, in which there were no Medicare savings. Medicare savings were in TEFRA only.

Additional cuts in fiscal year '91 will only exacerbate the inequity of Medicare shouldering such a massive share of federal budget cuts, and will be detrimental to our nation's health care system. Absent a determination to apply an across-the-board approach to freeze all federal spending, we cannot endorse further Medicare cuts.

II. PART B OF MEDICARE HAS HISTORICALLY BORNE A DISPROPORTIONATE SHARE OF MEDICARE FUNDING CUTS

We challenge the erroneous assertions of the press and others that physicians have been relatively insulated from past budget cuts. Contrary to press statements that Part B is "the only place that hasn't experienced the crunch," the reality is that Part B has been subjected to significant cuts in the form of freezes and budget reductions.

That Part B has a long history of budget cuts is borne out by the following facts:

- Medicare reimbursement and fees were frozen for most physicians for 40 months from July 1983 to 1987;
- Medicare reimbursement for selected procedures was cut by a total of 12% in 1987 and 1988, and special limits were imposed on physician fees for these procedures;
- The Medicare allowed amount for an office visit is only 79% of the amount actually billed by physicians to other patients (according to our 1989 survey); and
- Physicians presently are the only profession subject to federal price controls, the Maximum Allowable Actual Charge (MAAC) program.

Both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. (A summary of

recent actions limiting physician reimbursement and charges is attached as Appendix A.) The sum of the budget savings estimated by HCFA for ORA (1980), OBRA-81, TEFRA, DEFRA, COBRA, and OBRA-86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988*). This represents a 6.9% reduction in cumulative Part A outlays and a 10.9% reduction in cumulative Part B outlays. Thus, relative to the respective program sizes, Part B has absorbed a disproportionate share of total Medicare cuts -- about one and one-half times more than Part A.

The CBO, in a June, 1990 report of a study of budget savings over the last nine years, confirmed that Part B has absorbed disproportionate cuts. The CBO explained that

> [o]n average over the nine years from 1981 to 1989, the share of savings from the hospital inpatient sector was small relative to its share of spending . . . while the share of savings from the physician sector was disproportionately large. . . . Physicians and hospital outpatient departments account for a disproportionately large share of the overall savings, while savings from other service categories (hospital inpatient, nursing, and home health) are small in proportion to base disbursements for them.

Moreover, recent data obtained from HCFA show that, during the period from 1986 to 1989, the rate of increase of actual Medicare cash disbursements for physician services has been cut in half. The same is true for total Part B disbursements during that period. By contrast, total Part A disbursements accelerated during this period and, for the

*This GAO study is the most recent study available. We urge Members of the Committee to request GAO to update the study.

first time in a decade, the Part A expenditure growth rate for 1989 exceeded the Part B rate. (See Appendix B.)

Nevertheless, in a $96 billion program, some savings can be found and revenues can be obtained. If there is to be no across-the-board measure, and if you decide that Medicare spending cuts are unavoidable, we believe that any reductions made in Medicare should be done in proportion to actual outlays.

III. THE PROPOSED FISCAL YEAR '91 CUTS WILL UNDERMINE THE LANDMARK PAYMENT REFORMS OF OBRA-89

Just last December, Congress enacted dual landmark physician payment reforms: the Resource-Based Relative Value Scale (RBRVS) and the MVPS. RBRVS supplants Medicare's historical "reasonable charge" method of physician payment with a fee schedule. MVPS will, for the first time, allow Congress and the profession to monitor the volume of physician services provided to beneficiaries.

As you know, the RBRVS methodology is the result of years of research and evaluation, and is designed to ameliorate the reimbursement inequities of the reasonable charge system. RBRVS, which will take effect in 1992, is to be implemented in a budget-neutral manner.

Implementation of RBRVS will have significant effects of transferring resources among medical specialties and geographic regions of the U.S. Congress crafted a five-year transition period to ameliorate any dislocations that these resource shifts might cause. In addition, although RBRVS is methodologically sound, it has not been implemented in any major setting. Therefore, caution is necessary so that we can understand the impact of RBRVS implementation and correct problems that arise during the transition period.

Despite the magnitude of the OBRA-89 physician payment reforms, the Administration proposed $2.2 billion of additional Part B cuts immediately after enactment. These cuts include:

- reducing payments for certain procedures and localities;
- allowing a full MEI update only for primary care services;
- reducing payment for radiology and anesthesia services; and
- reforming payments for assistants at surgery and surgical global fees.

By proposing these and other cuts, the Administration is proposing to undermine RBRVS before the methodology is even implemented. The budget cuts eviscerate the concept of budget neutrality upon which RBRVS is premised by "chipping away" at the payment levels in effect when Congress enacted the fee schedule. Consequently, the fundamental goal of RBRVS--redistribution of resources--will be subverted; there simply will not be adequate funds available to transfer from one specialty or geographic region to another. As a result, individuals residing in underserved areas such as rural areas will likely remain underserved.

In addition to undermining the budget neutrality requirement of RBRVS, the proposed cuts are simply inconsistent with effective implementation of RBRVS and MVPS. The OBRA-89 payment reforms are the product of innumerable hours of study, refinement and honing; it would be ultimately inefficient and disruptive to "tinker" with their foundations before they are implemented.

Additional items, proposed by the Administration in June, should also be rejected. These proposals include: adoption of Medicaid Prescription

Drug Formularies with mandatory therapeutic substitution, establishment of a $1 charge for processing of non-electronic claims, and reduction of the End Stage Renal Disease payment rate by $10 and the intraocular lens payment rate to $100.

The drug provisions, which would radically change prescribing and dispensing practices for the Medicaid population, are highly objectionable. The concept of therapeutic substitution is controversial, and could severely impact on the quality of care available to the Medicaid population. The $1 charge for processing each non-electronic claim is yet another major problem. It is our understanding that if all physicians switched to electronic billing in 1991 to avoid the charge, Medicare carriers would not be able to administer all those claims. Therefore, this provision amounts to nothing more than a tax on physicians.

ADDITIONAL MEDICARE ISSUES

Although the proposed budget cuts are of paramount importance, they are not our only concern. We would like to take this opportunity to call to the Committee's attention several other vital issues.

First, the OBRA-89 physician payment provisions contain a serious internal inconsistency. As stated previously, RBRVS will be implemented in 1992, and will base payment on the resources required to provide medical services. In addition, OBRA-89 will replace in 1991 the existing MAAC program--which limits physician billings by a complex formula based upon 1984 actual charges--with a phased-in cap equal to a percentage of the RBRVS payment amount (phased to 115% by 1993).

The inconsistency in this scheme is that RBRVS will not be implemented until 1992, yet the billing limits, which are supposed to be based on RBRVS payments, will begin to be implemented in 1991 at 125%. For 1991, however, the cap will be 125% of the existing CPR system. The 1991 balance billing cap could cause serious reductions in the fees physicians would otherwise be allowed to charge in 1991 for all services provided in traditionally under-compensated rural areas and for the "undervalued" evaluation and management services. This potential for wide swings in allowed fees in 1991 and 1992 introduces such irrationality as to cause physicians (and affected patients) to lose confidence in a measure intended as beneficial "reform."

We do not believe that physicians should be subject to arbitrary billing limits. We recognize, however, that the new system was designed to establish limits based upon defined amounts reflecting the RBRVS shift among services and regions. We believe that the new system for billing limitations is fundamentally flawed, and this deficiency is further aggravated in that its implementation precedes implementation of RBRVS. We urge that legislation be incorporated in the pending reconciliation bill to delay implementation of the new billing system for one year -- until 1992.

Second, there is growing concern about implementation of the Medicare patient transfer provisions. We strongly support a proposal developed by Representative Laughlin, H.R. 4495, that would require PRO review of the medical issues involved in patient transfer cases.

CONCLUSION

In conclusion, Mr. Chairman, Medicare has been subjected to years of significant budget cuts, and has recently attained massive reforms in physician payment. Although we do not believe that RBRVS is a panacea for all physician payment issues, it is a well-grounded effort at achieving equity in reimbursement. We urge you to prevent the undermining of RBRVS, and to protect the program from further cuts that, if imposed, will jeopardize the health care of the nation's elderly and disabled.

I will be pleased to respond to your questions at the appropriate time.

APPENDIX A

62 Physician Reimbursement Cuts and Freezes Under Medicare

Since the inception of Medicare, Congress and the Department of Health and Human Services have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for these services.

In 1969, prevailing charge levels were lowered from the 90th percentile to the 83rd percentile of customary charges. In 1970, prevailing charge levels were lowered to the 75th percentile of customary charges. For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.

In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months -- until May 1974.

In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charge levels. In 1976, the Medicare Economic Index (MEI) as used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.

Starting with the Deficit Reduction Act of 1984 (DRA) further and substantial limits were imposed on physician reimbursement and charges for services provided Medicare beneficiaries. The DRA modified physician reimbursement in the following ways:

Two classes of physicians were created: "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;

Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (if no freeze had been imposed by the DRA, the economic index would have allowed a 3.34% increase of prevailing charge levels on July 1, 1984);

The scheduled July 1, 1984 increase in fee profiles was eliminated, and the future annual update in fee profiles was delayed from July 1 to October 1, with the next increase set for October 1, 1985; and

Fees for services provided Medicare beneficiaries by "non-participating physicians" were frozen during this 15-month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

- American Medical Association -
Department of Federal Legislation, Division of Legislative Activities

The Emergency Extension Act again froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This Act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86. Further legislation extended the Extension Act, with fee and reimbursement levels again frozen through March 15, 1986.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) yet again extended the Medicare reimbursement freeze: i) the freeze on Medicare reimbursement and charges for non-participating physicians was continued through December 31, 1986; and ii) the freeze in the customary and prevailing charge levels for participating physicians was allowed to end May 1, 1986, with the prevailing charge increase for participating physicians set at only 4.15%.

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) made substantial modifications in physician reimbursement and fee limits.

Reimbursement - Both participating and non-participating physicians were allowed an equal 3.2% update in Medicare prevailing charge levels beginning January 1, 1987. Beginning on January 1, 1987, prevailing charges for non-participating physicians were set at 96% of the prevailing charge levels allowed participating physicians.

Fees - The freeze on actual charges of non-participating physicians expired on December 31, 1986 and was replaced by Maximum Allowable Actual Charge (MAAC) limits. Each MAAC is determined by a complicated formula applicable to every charge of every individual physician. Physicians are subject to substantial penalties for violation of MAAC limits. MAAC limits are determined as follows:

If the physician's actual charge for any given service is at or above 115% of the prevailing charge (as determined from year to year), the actual charge for that service may be increased by no more than 1%. If the actual charge is less than 115% of the prevailing charge, that charge may be increased by the greater of 1% or as follows:

January 1, 1987 - charge increases were limited to 1/4th of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1988 - charge increases were limited to 1/3rd of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1989 - charge increases are limited to 1/2 of the difference between the actual charge and 115% of the Medicare prevailing charge; and

January 1, 1990 and subsequent years - actual charges may be increased to 115% of the Medicare prevailing charge.

OBRA-86 reduced prevailing charge levels for cataract surgery by 10% in 1987 plus another 2% in 1988. A limit of 4 base units for anesthesia services related to cataract surgery also was set. Special limits on fees for these services also were imposed, with actual charges limited to 1/2 the amount by which the charge exceeds 125% of the new prevailing charge in 1987 and to 125% of the prevailing charge in 1988 and thereafter.

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) made further substantial modifications in Medicare payment for physicians' services:

Three-Month Freeze - Prevailing and customary charge levels were maintained at the levels in effect during 1987 during the three-month period ending on March 31, 1988. Also during this three-month period, MAACs were kept at the amount determined for 1987. 1988 MAACs did not go into effect until April 1, 1988.

Sequestration - The Gramm-Rudman-Hollings sequestration reduced payments for physicians' services by 2.324% through March 1988.

Medicare Economic Index (MEI) - For services provided by participating physicians after March 31, 1988, the MEI increase was limited to 3.6% for primary care services and 1% for other physicians' services. Increases for the services of non-participating physicians were set at 0.5% less than the increase allowed participating physicians (3.1% and 0.5%). For physicians' services furnished in 1989, the increase for participating physicians is to be 3% for primary care services and 1% for other physicians' services. The increase in 1989 for non-participating physicians will be 0.5% less.

Reductions in Prevailing Charge Levels - The following physicians' services provided after March 31, 1988 were subjected to "reasonable charge" reductions: bronchoscopy (Codes 31622-31626), carpal tunnel repair (Code 64721), cataract surgery (Codes 66830-66985), coronary artery bypass surgery (Codes 33510-33528), knee arthroscopy (Codes 29880-29881), diagnostic and/or therapeutic dilation and curettage (Code 58120), knee arthroplasty (Codes 27446-27447), pacemaker implantation (Codes 33206-33208), total hip replacement (Codes 27130-27132), suprapubic prostatectomy (Code 55821), transuretheral resection of the prostate (Code 52601), and upper gastrointestinal endoscopy (Codes 43235-43239). The 1987 prevailing charge levels for these services initially were reduced by 2%. Further reductions of up to 15% were implemented according to a sliding scale formula for services between 85% and 150% of the national average.

Where a non-participating physician's allowed charge is reduced by the application of this provision (or for cataract procedures, or physician supervision of certified registered nurse-anesthetists), the physician may not charge the beneficiary more than 125% of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous 12-month period exceeds the 125% level. In subsequent years, the maximum allowed charge will be set at 125% of the prevailing charge. Where a physician "knowingly and willfully" imposes a charge in violation of this provision, the Secretary is authorized to apply sanctions (civil

money penalties, assessments, and five-year barring) against the physician. These charge reductions will not apply to services furnished after the earlier of December 31, 1990 or one year after the Secretary reports to Congress on development of the RVS.

Payment for Physician Anesthesia Services - In determining the amount allowed for the medical direction of two or more nurse anesthetists (in which services are provided in whole or in part concurrently) for services provided after March 31, 1988 and prior to January 1, 1991, the number of base units recognized for the medical direction (other than for cataract surgery or an iridectomy) will be reduced from current levels by: 10% where the medical direction is of two nurse anesthetists concurrently; 25% where the medical direction is of three nurse anesthetists concurrently; and 40% where the medical direction is of four nurse anesthetists concurrently. Where the anesthesia services are for concurrent cataract surgery or an iridectomy procedure provided after December 31, 1989 and before January 1, 1991, the number of base units that will be recognized for the medical direction will be reduced from current levels by 10%.

Fee Schedules for Radiologist Services - Medicare payments for radiologist services will be the lesser of 80% of the actual charge for the service or the amount provided under a fee schedule. "Radiologist services" are defined to include radiologic services performed by, or under the direction or supervision of, a physician who is certified or eligible to be certified by the American Board of Radiology, or a physician for whom radiologic services account for at least 50% of his or her Medicare billings.

Radiology Charge Limitations - Where radiologist services are provided by non-participating physicians or suppliers after 1988 and where payment is made pursuant to the fee schedule, the maximum amount that may be billed will be subject to a "limiting charge." The limiting charge will apply as follows: in 1989 - 125% of the amount specified in the fee schedule; in 1990 - 120% of the amount specified in the fee schedule; and after 1990 - 115% of the amount specified in the fee schedule. Where a charge is "knowingly and willfully" imposed above the limiting charge, sanctions may be applied.

Limits on Payment for Ophthalmic Ultrasound - Effective for services provided after March 31, 1988, the prevailing charge level for A-mode ophthalmic ultrasound procedures may not exceed 5% of the prevailing charge level established for extracapsular cataract removal with lens implantation. Limits on actual charges for this service also apply.

Customary Charges for Services of New Physicians - For physicians who do not have adequate actual charge data, customary charges are to be set at 80% of the prevailing charge for the service in the area. (Previously, these charges were set at the 50th percentile of customary charges in the area, an amount usually above prevailing charge levels.) This limit is not applicable for primary care services or for services provided in designated rural areas.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) made the following significant modifications to physician payment under Medicare:

Physician Payment Reform - Beginning in 1992, payment for physicians' services, for which payment presently is on a "reasonable charge" basis or in accordance with the radiology fee schedule, will be based on the lesser of the actual charge for the service or the amount determined under the fee schedule for a particular year.

Medicare Volume Performance Standard (MVPS) Rates of Increase - By April 15 of each year (beginning with 1990) the Secretary will present to Congress a recommendation on MVPS rates of increase for all physicians' services and for each category of such services for the upcoming fiscal year.

Extension of Sequestration - The 2% sequestration reduction in payment will be maintained and extended to March 31, 1990. After this date, a 1.3% partial sequester will continue throughout the fiscal year. (The Part A sequester of 2% is continued through December 31, 1989, with a 1.3% partial sequester continuing throughout the fiscal year.)

Delay in Update and Application of the Medicare Economic Index

- Updates - Part B payment increases or adjustments scheduled to occur as of January 1, 1990 (i.e., adjustments to customary or prevailing charges, fee schedule amounts, MAACS, and other limits on actual charges) shall be postponed until April 1, 1990. In lieu of any increase or adjustment from January 1, 1990 to March 31, 1990, the amount of payment and limits for all Part B covered services (other than ambulance and clinical diagnostic laboratory services) will be the same as those in effect on December 31, 1989.

- Medicare Economic Index (MEI) Percentage Increase - The percentage increase in the MEI for services furnished in 1990 (after March 31, 1990) will be:

  - the full percentage increase (5.3%) as would otherwise be determined for primary care services (office medical services, certain eye examinations, emergency department services, home medical services, skilled nursing, intermediate care and long-term care medical services, and nursing home, board home, domiciliary or custodial care medical services);

  - 2% for other services (not including primary care services); and

  - 0% for radiology, anesthesia and "overvalued" services.

Reduction in Payments for Overvalued Services - Medicare payment for certain physicians' services provided from April 1, 1990 through December 31, 1990 and identified as "overvalued" will be reduced.

Reduction in Payments for Radiology Services

- Fee Schedules for Radiologists' Services - The conversion factors used to compute fee schedules for radiologists' services (excluding portable x-ray services) furnished in 1990 (after March 31, 1990) shall be 96% of the factors applied as of December 31, 1989.

Customary Charge Levels for New Physicians - In determining customary charge levels for physicians' services furnished in 1990 and beyond (on and after April 1, 1990) by "new" physicians -- physicians for whom adequate actual charge data are not yet available -- the Secretary shall set customary charge levels at the start of the second calendar year in the practice at no higher than 85% of the prevailing charge levels.

Payment Limits for Services Furnished by More Than One Specialty - The Secretary shall designate certain surgical, radiological and diagnostic physicians' services that: (1) account for a high volume of Part B expenditures; and (2) have varying prevailing charges, depending upon the specialty of the physician furnishing the service. For any such designated service performed after March 31, 1990 the prevailing charge may not exceed the prevailing charge or fee schedule amount for the specialty that furnishes the service most frequently nationally. Where a non-participating physician provides one of these services after March 31, 1990, special MAACs will apply. (The charge may not exceed 125% of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous year exceeds the 125% level in the first year, and 125% of the reduced amount in subsequent years.)

Balance Billing Limitations - For 1991 the limiting charge shall be the lesser of 125% of the prevailing charge levels or the MAAC amount. In 1992, the limit shall be the lesser of the MAAC amount or 120% of the fee schedule amount for non-participating physicians. For years 1993 and after, the limit shall be 115% of the non-participating physicians' payment schedule. If a non-participating physician knowingly and willfully bills on a repeated basis an actual charge in excess of the limiting charge amount, the Secretary may apply sanctions against the physician.

Effective April 1, 1990, payment for physicians' services provided beneficiaries who are eligible for medical assistance, including qualified Medicare beneficiaries, will only be made on an assigned basis.

Physician Submission of Claims - Physicians and suppliers shall submit claim forms (whether or not the claim is assigned) for care provided to Medicare patients on or after September 1, 1990. Claims must be submitted within one year and no charge may be imposed for completing and submitting such forms. If a physician fails to submit an assigned claim as required, the Secretary shall reduce the amount otherwise paid by 10%. If a nonassigned claim is submitted sanctions would apply.

February, 1990

APPENDIX B

Actual Medicare Cash Disbursements, Fiscal Years 1986-1989

	1986	1987	1988	1989
Dollar outlays (millions):				
Part A benefit payments	$49,018	$49,967	$52,022	$57,433
Inpatient hospital	46,055	46,840	48,787	52,384
Skilled nursing facility	582	623	720	2,193
Home health	2,195	2,287	2,261	2,534
Hospice	35	63	90	120
PRO activity	151	154	164	202
Part B benefit payments	25,169	29,937	33,682	36,867
Physician	18,553	21,926	24,243	26,150
Outpatient*	4,922	5,780	6,456	7,329
Home health	47	48	56	48
Group practice plans	953	1,336	1,952	2,218
Independent labs	694	847	975	1,122
Total benefit payments	74,187	79,904	85,704	94,300
Administrative expenses	1,716	1,736	1,972	2,154
Total outlays	75,903	81,640	87,676	96,454
Pct. change from prev. year:				
Part A benefit payments	-	1.9%	4.1%	10.4%
Inpatient hospital	-	1.7	4.2	7.4
Skilled nursing facility	-	7.0	15.6	204.6
Home health	-	4.2	-1.1	12.1
Hospice	-	80.0	42.9	33.3
Part B benefit payments	-	18.9	12.5	9.5
Physician	-	18.2	10.6	7.9
Outpatient*	-	17.4	11.7	13.5
Home health	-	2.1	16.7	-14.3
Group practice plans	-	40.2	46.1	13.6
Independent labs	-	22.0	15.1	15.1
Total benefit payments	-	7.9	7.3	10.0
Administrative expenses	-	1.2	13.6	9.2
Total outlays	-	7.6	7.4	10.0

Source: Tables provided by HCFA Office of the Actuary and Office of Budget Administration.

Prepared by the AMA Center for Health Policy Research.

*86% of outpatient services are provided in hospital settings.

2/22/90
7437v

Mr. WAXMAN. Thank you.
Dr. Ebert.

STATEMENT OF PAUL A. EBERT

Mr. EBERT. Thank you, Mr. Chairman, members of the committee.

I will be very brief today and try to address the issues that relate to surgery, per se. Since we haven't any discussion or public announcement of discussions that you people have had regarding the budget, I will take it that the President's proposed budget is the subject to address.

Actually, as you are aware, the college has supported the programs to support payment—physician payment reform. We also recognize it is very important a program as large as this have its changes conducted as ordinarily as possible, and with the further sweeping legislation last year, the RBRVS, is not yet put in place.

We are a little concerned with some of the specific recommendations that the President's budget brought forth. Most explicitly is the use of payment for assistants at surgery. We think this is really quality of care issue, and that reduction of payments for assistants will not allow the surgeon, when the assistant is needed in many instances, to be guaranteed the assistant is available.

The college has always supported the concept that the most important aspect of an operation is to have a qualified assistant present. In idealistic terms, this might be another surgeon of comparable skills. We certainly know in many instances it would be someone other than a surgeon, but it is clear when it is needed, it should be fairly reimbursed and not reduce the surgeon's fee, because I think the last thing one would want to do is adversely affect the quality of care.

We have not been supportive of the concept that the MEI update would be only for primary care services. We really agree with the Secretary, that should be for an across-the-board update, because we are concerned many overvalued procedures reduced in the past since the RBRVS is not complete and since the second phase has not been reported, we don't know whether one would know whether things are overvalued or not?

Once you are on the overvalued list, it is very difficult to be removed from that location. Clearly, we have been disappointed in the concept of the global surgical fees be reduced simply because hospitalizations have been reduced.

We think it is wonderful patients get out of the hospital earlier and can be ambulated quickly, but you have to recognize costs included in global surgery fee is the same—or whether he sees it in his office is actually more expensive for him to see it in the office possibly, more inconvenient for the patient, but it doesn't make sense to reduce a global fee and ask the surgeons to see the patient in the office sometimes two or three times more directly than they normally would when patients were in the hospital for a longer period of time.

I think we are most concerned that whatever direction one takes that it be somewhat orderly and not just disrupt the plans that

were put forth last year. Obviously, I would be happy to answe any questions on the printed testimony.

[Testimony resumes on p. 85.]

[The prepared statement of Dr. Ebert follows:]

Statement
of the
American College of Surgeons
to the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
Presented by
Paul A. Ebert, MD, FACS

Re: Proposed Reductions in FY 1991 Medicare Budget for Physicians Services

July 27, 1990

Mr. Chairman and members of the Subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons (ACS). The College appreciates this opportunity to present its views on the fiscal year (FY) 1991 Medicare budget.

Mr. Chairman, as you know, the American College of Surgeons was an active participant in and supporter of the physician payment reform legislation passed last fall by the Congress. The College was, and still is, very committed to working with Congress to develop reasonable approaches to public policy problems relating to federal programs like Medicare. We are also committed to and have been working with the Secretary of Health and Human Services and his staff to implement the new physician payment reform program.

Mr. Chairman, today I would like to comment on the proposed FY 1991 budget. I will discuss several elements in the physician payment reform legislation and some other ideas that have been proposed as part of the budget process. I realize that much has happened since the President forwarded his proposed 1991 budget to Congress in January, and that much continues to be discussed in private budget talks.

Obviously, the College is not privy to the current discussions between Congressional leaders and the Administration. Since none of these talks have yet produced specific proposals, I will concentrate my general comments on the President's proposed budget because those proposals remain under discussion despite the Congress' earlier rejection of the Administration's 1991 budget plan. Naturally, I would be pleased to address any specific questions that you might have about subjects on which I do not touch.

We believe that changes in the design of a program as complex and as important as Medicare should proceed in the most orderly manner possible. Disruptions should be kept to a minimum, and changes in Medicare policy should be judged on their long-term implications for patient access to cost effective, high-quality surgical and medical services. In our judgment, the Administration's 1991 budget proposals meet none of these criteria and should be rejected. We recognize that this country has a serious deficit problem, which is one reason the College

felt an obligation to support the physician payment reform as a means to revise the payment system and help moderate the escalation in costs. This reform will make an impact over time if the program is allowed to be implemented in an orderly manner. We recommend that federal policymakers give the Medicare payment reform plan a chance to take effect before adopting additional policy changes that could interfere with its implementation and destroy its long run promise.

Assistant-at-Surgery

Consider, for example, the recommendation in the President's budget related to the use of and payment for an assistant-at-surgery. The College believes that the Committee should firmly reject this proposal, which reflects a lack of understanding of why an assistant-at-surgery may be needed during an operation. In addition, it proposes to simply ignore the fact that the use of an assistant-at-surgery involves the application skills and knowledge that must be fairly valued and reimbursed by the Medicare program. I'd like to spend a few moments to expand on our concerns in this area.

The College has developed guidelines for determining when an assistant-at-surgery is required for a procedure. We believe the application of the guidelines has a direct bearing on both the

quality and safety of the surgical services that are provided to a patient. The factors that a principal surgeon should consider in deciding when an assistant is needed include:

- The degree to which the operation is complex and technically demanding, so that joint efforts of the principal surgeon and one or more assisting physicians contribute meaningfully to the successful treatment of the patient.

- The expected effect of the use of an assistant on the patient's mortality and morbidity, including that related to blood loss and duration of the operation.

- The degree to which the patient's history indicates that there is a substantial risk of complications arising in the course of the operation that would require the services of an assistant-at-surgery to avoid the increased risk of mortality or morbidity.

On the basis of these criteria, it may be possible to identify some procedures that almost always require the use of an assistant-at-surgery, and those for which an assistant is almost never required. However, it should be emphasized that for many procedures, professional judgments of the surgeons are needed to determine whether an assistant should be used in a specific case. And, the College believes that the responsibility for determining the need for an assistant-at-surgery rests squarely with those

principal surgeons. Thus, it is our view that payment for assistance-at-surgery should be made only when the services of an assistant have been ordered by the operating surgeon.

Ideally, an assistant-at-surgery should be a surgeon or an individual who has the necessary qualifications to participate in a particular operation and who actively assists the surgeon in performing the surgical procedure. In many teaching hospitals, for example, surgical residents are frequently available to provide such assistance. However, an extra pair of surgically trained hands is not always available when needed, so the individual circumstances of each particular case must dictate whether assistance from a non-surgeon is appropriate.

The Committee should also know, Mr. Chairman, that at least one state, New Jersey, actually requires the presence of a physician as an assistant during major surgery, so that the surgeon is allowed no discretion with regard to this matter. In other areas of the country, the use of a physician as an assistant-at-surgery is required for certain major operations by the quality assurance program of the hospital.

As you know, the costs of the services of a non-physician assistant-at-surgery are covered in various ways under the Part A portion of the Medicare program, while payments for the services of a physician who performs as an assistant are made under Part B. We believe that physicians who serve as assistants-at-surgery

should be reasonably compensated for their services, as should any physician who provides a professional service. It is also our view that a physician who is not required as an assistant should not be paid for this service.

Finally, Mr. Chairman, in the legislation passed by Congress last year, you directed the Physician Payment Review Commission (PPRC) to conduct a study of Medicare policies that are related to the appropriate use of an assistant-at-surgery and the payment rules that should be applied under the new payment system. We are working with the PPRC and with officials in the Administration to provide them with our recommendations so that good policy in this area can be developed. We hope that you will wait for the results of this additional study and reject the Administration's proposals in this area.

Medicare Economic Index (MEI) Update for Physicians' Services

Another provision in the President's budget recommends that an MEI update be provided only for primary care services. According to the Administration, this recommendation would improve equity in relative payment levels for physicians' services. But in his October 1989 report to Congress entitled Implementation of a National Fee Schedule, Secretary Sullivan observed that "significant lead time is needed before implementation of a new payment system base fully on RBRVS. This is needed to assure reasonable accuracy in payment determinations."

Less than a year ago, Congress approved the adoption of a new Medicare fee schedule plan that will make adjustments in the relative value of various physicians' services on a phased-in basis. Congress also agreed that the RBRVS would be implemented only after further research has been completed to determine exactly what the relative values among such services are. We think that was prudent decision. In addition, preliminary estimates using the RBRVS suggest that some non-primary care services are undervalued. Thus, until the new plan goes into effect, we believe that all physicians' services should be subjected to the same update rules. If a different approach is taken, the validity of the relative RBRVS will be compromised.

"Overvalued" Services

We are also disappointed with the Administration's plan to again single out certain procedures, including many important surgical procedures, for payment reductions on the grounds that those services are "overvalued" when compared with a resource-based Medicare fee schedule -- a schedule that hasn't even been established yet.

The information and data upon which the "overvalued" proposal is based are, in our judgment, flawed, inaccurate, and certainly incomplete. Our observations are borne out by the fact that currently there are major studies under way to re-examine

certain services. These studies have been undertaken because of legitimate doubts that have been raised about the methodology and the quality of the original research effort that was used to justify payment reductions for those services. Moreover, there are many other physician specialties that are being studied for the first time, and the results of these studies will affect the final values assigned to all Medicare services. We think that this work should be completed and thoroughly evaluated before further arbitrary and selective payment adjustments are made solely for short-term budgetary goals.

The College believes that Congress was correct last fall when it included in the statute a specific time frame and instructions to be followed by the Secretary and the PPRC before other payment modifications are made on the basis of limited information.

Surgical Global Fees

The Administration's budget proposal would also reduce global surgical fees to reflect recent decreases in the average inpatient length of stay among Medicare patients. In our opinion, this recommendation makes no sense whatsoever. In the first place, we see no evidence at all that physician time and effort related to surgical patients are linked to the length of stay. These patients must be followed after the operation, and postoperative visits are provided on an outpatient rather than

inpatient basis. In fact, earlier hospital discharges may actually increase the amount of physician effort that is needed to monitor and/or treat the patient during the recovery period. Secondly, the Administration seems to have overlooked the fact that increasing numbers of surgical procedures are performed on an outpatient basis. It certainly makes no sense to use data on inpatient length of stay to make payment reductions for surgical services that are typically provided on an outpatient basis.

Once again, Mr. Chairman, the Administration seems to be ignoring the payment legislation that was passed just last year, in which you directed the establishment of standard definitions and procedure codes for all physician services, including global surgical services. We have met on several occasions with Administration officials, including just a few days ago, to consider options for developing standardized definitions of global surgical services. It is also important to note that the values assigned to packages of services are to be based upon yet-to-be-completed estimates of the resource inputs needed to provide those services, including those related to postoperative care. The Administration budget plan calls for making reductions in payments without taking any of these factors into consideration.

Budgetary Options

In summary, Mr. Chairman, we are very disturbed by the Administration's 1991 budget package, because it totally disregards the steps that have been taken to bring about an orderly revision in physician payment policies. We recommend that virtually all of these proposals be rejected.

Nevertheless, we also recognize that budget realities may compel the Committee to achieve budgetary savings in some form. Thus, the American College of Surgeons urges that if such actions must be made, they take the form of across-the-board fee reductions that will be applicable to all physicians' services for the upcoming period prior to implementation of the new payment plan. Even across-the-board reductions that would apply to the Medicare program under a budget sequestration order would make more sense to us than actions that would disrupt the phased-in changes scheduled to begin in 1992.

Again, Mr. Chairman, the American College of Surgeons appreciates this opportunity to express its views, and I would be pleased to answer any questions you may have.

Mr. WAXMAN. Thank you very much.
Dr. Davies.

STATEMENT OF NICHOLAS E. DAVIES

Mr. DAVIES. Thank you, Mr. Chairman.

The American College of Physicians, it is pleased to have this opportunity to appear before you today to present our views on the budget.

I am Nicholas Davies, president-elect of the College of Practicing Interns, Piedmont Hospital in Atlanta, and accompanying me is Debra Prout, director of our public policy here at the college.

First of all, I would like to thank you, Mr. Chairman, and I would like to thank Dr. Rowland for coming to Atlanta earlier this year and hearing about our problems in Georgia.

The people of Georgia, the physicians of Georgia appreciated this very much. I just wanted you to know that.

I would also like to thank the members of this committee for your leadership in securing approval of a payment reform proposal in last year's budget reconciliation package. Your support for enactment of a resource-based value scale as a function of the Medicare fee schedule has taken us a long way towards reform of the payment system.

However, much work remains to be done if we are to ensure that the Medicare program meets the goal of paying an appropriate price for appropriate service delivered under proper conditions to the beneficiary.

The efforts of this committee over the past several years have systematically laid the groundwork towards far-reaching reform of the physician payment system. We must continue to build our efforts such as these.

In order to do so we must move beyond the types of proposals found in administrative budget message and now under consideration by budget negotiators and work to develop solutions to many service health policy problems facing the Nation.

In the past, we have advocated that all of us must do our part to meet deficit reduction goals. However, we feel the health care system is running out of contributions that can be made to deficit reduction.

We are alarmed by the failing infrastructure of our health care delivery system. We are especially alarmed by the absence of a blue print for health care policy in the 1990's and into the next century. We know that many members of this committee and the Congress share this frustration.

We would urge you to redouble your efforts to force a meaningful discussion of deficit reduction policies with a eye to putting this annual cycle of constructing of budgetary savings smorgasbord from the Medicare program at the expense of crafting comprehensive health policy.

We would also urge you to oppose any efforts to short cut or minimize the appropriate scrutiny of proposals arrived at through the summit process. They must be subjected to a full analysis as to the implications for the health care system of this country.

As urgent as the present budgetary situation is, we cannot stand by and allow a budget cut frenzy of unprecedented magnitude to justify the public health. Physicians are closing practices, countless patients are going unserved and the system faces mounting problems.

The college believes that the administration's proposals must be evaluated in terms of their consistency with the direction for longer term reform that was charted by the Omnibus Reconciliation Act of 1989.

We share the view expressed by PPRC that legislate sharp reductions in payment rates to take effect while we are in the process of implementing a major reform for physicians payment could make the achievement of the objectives in their form more difficult.

We will send an important message to those still in medical training regarding implications of reform and will thereby enhance recruitment into the primary care disciplines.

We strongly support efforts to correct the technical problem which has surfaced toward primary care service with respect to implementation of the 125 percent balance billing limit in 1991. We urge that you continue to work to solve this problem in a manner consistent with the overall objectives of payment reform.

With respect to the next steps, the first task is to accelerate efforts to fully analyze the reasons for increases in expenditure in Medicare part B. Through focused hearings and its charge to PPRC and in its direction to HCFA, this committee can promote an examination of growth trends in part B in as disaggregated and specific a fashion as possible.

The second task we would urge must be immediately to move toward with a new way of reviewing medical necessity and utilization. Current approaches are antagonizing the physician community.

Mr. Chairman, we recognize the difficult decisions facing this committee. Even as you take these short-term steps, we urge you to work towards developing a comprehensive health policy that can end this disruptive annual cycle of budget-driven decisions.

Some of the steps we have outlined today would help us move in the direction of a restructured and improved Medicare program and would lay the groundwork for comprehensive reform of the health care system.

Finally, Mr. Chairman, we note in the strongest possible terms our concern that the cumulative effect of past budget cutting efforts coupled with fiscal year 1991 cutbacks are potentially unprecedented magnitude pose a direct and serious threat to the integrity, stability and ultimately the viability of the Medicare and Medicaid programs.

Thank you very much.

[Testimony resumes on p. 98.]

[The prepared statement of Dr. Davies follows:]

STATEMENT OF THE

AMERICAN COLLEGE OF PHYSICIANS

TO THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

July 27, 1990

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to present our views on budget reconciliation issues relating to physician payments under Part B of Medicare and on other matters that may be considered during the budget reconciliation process.

The College represents over 70,000 physicians practicing internal medicine and its subspecialties. Since its founding in 1915, the College has dedicated itself to upholding the highest standards of medical care. I am Nicholas E. Davies, MD, FACP, President-Elect of the College and a practicing internist at Piedmont Hospital in Atlanta, Georgia. Accompanying me today is Deborah M. Prout, Director of Public Policy for the College.

Today's hearing occurs at an important juncture in our collective efforts to achieve reform of the physician payment system and to meet deficit reduction targets. We would like to begin by thanking the members of this committee for your leadership in securing approval of a payment reform proposal in last year's budget reconciliation package. Your support

for enactment of a resource-based relative value scale as the foundation for a Medicare fee schedule has taken us a long way towards reform of the payment system. However, much work remains to be done if we are to ensure that the Medicare program meets the goal of paying an appropriate price for an appropriate service delivered under the proper conditions to the beneficiary.

We would like to offer our comments on fiscal year 1991 budget reconciliation issues and related matters which may be included in the reconciliation package. In addition, we want to highlight several critical issues that need to be considered in the larger context of next steps needed to move forward in reform of our health care system.

Budget Process and Administration Fiscal Year 1991 Budget Proposals

Earlier this year, the Administration proposed a series of recommendations for reducing spending under Medicare Part B by $2.16 billion in fiscal year 1991. It is our understanding that as the budget summit proceeds this number may be far higher, and that cutbacks may be recommended for the Medicaid program. In March, in general reaction to this year's deficit reduction exercise, we questioned the wisdom of continuing to focus significant energies and attention on meeting budgetary requirements for annual spending reductions in the face of mounting evidence that our health care system is in serious need of comprehensive reform. Now, as we watch the foundering budget summit process, we have very serious concerns about the future of the programs under this Subcommittee's

jurisdiction, and about the future of the health care system in this country.

The efforts of this committee over the past several years have systematically laid the groundwork towards far-reaching reform of the physician payment system. We must continue to build on efforts such as these. In order to do so, we must move beyond the types of proposals found in the Administration's budget message and now under consideration by budget negotiators, and work to develop solutions to the many serious health policy problems facing the nation.

This year we were confronted with yet another series of Administration budgetary proposals that appear to have been developed with an eye principally to budgetary savings and only secondarily, if at all, to much needed comprehensive policy goals. We would characterize the Administration's proposals for fiscal year 1991 as uninspiring, at best, and in some instances potentially harmful to long term policy interests.

For over eight years the Congress and various constituencies such as the College have struggled to find ways to channel required reductions in domestic spending in a manner which will promote good policy, or at a minimum do the least amount of harm. We are frustrated that after numerous years at this exercise we seem still to be falling short of resolving our national budgetary crisis. And consequently, this year the Medicare program once again is being asked to bear the brunt of spending reductions.

We are increasingly troubled that the annual deficit reduction exercise faced by this committee and by the Congress appears to assume that an endless supply of savings is available year after year. This unceasing preoccupation with deficit reduction now appears to threaten the development of sound health policies and comprehensive reform.

In the past we have advocated that all of us must do our part to meet deficit reduction goals. However, we fear that the health care system is running out of contributions that can be made to deficit reduction. We are alarmed by the failing infrastructure of our health care delivery system and by the absence of a blueprint for health policy in the 1990s and into the next century. We know that many members of this committee and of the Congress share this frustration. Accordingly, although it is not the ostensible subject of today's hearing we would urge you to redouble your efforts to force a meaningful discussion of deficit reduction policies with an eye to ending this annual cycle of constructing a budgetary savings smorgasbord from the Medicare program, at the expense of crafting comprehensive health policy.

We would also urge you to oppose any efforts to shortcut or minimize the appropriate scrutiny of proposals arrived at through the summit process. They must be subjected to a full analysis as to their implications for the health care system of this country. As urgent as the present budget situation is, we cannot stand by and allow a budget cutting frenzy of potentially unprecedented magnitude to jeopardize the public health. Physicians are closing their practices, countless patients are going unserved, and the system faces mounting problems. The College, and its

members, will do all that we can to support you in your efforts to ensure that reasonble process and full analysis occur in this year's budget debate.

However, we realize that as a practical matter, even given the apparent significant breakthrough in the Administration's overall approach to deficit reduction, this committee will face the task of needing to once again meet certain budgetary objectives. We question the feasibility of meeting savings of the magnitude that may be demanded, and would urge that these demands be closely scrutinized and not automatically accepted.

The College was an early advocate of achieving necessary short-term budget savings in a manner consonant with long-term payment reform through reducing overpriced procedures and increasing support for primary care services. At that time, it was clear that such alterations could appropriately be made. Now, we would urge that as the committee considers the Administration's proposals for updating primary care services, reducing payments for certain overvalued procedures, and reducing payment for overvalued localities, it is essential that this continue to be done in a manner consistent with the principles laid out in the payment reform package enacted last year.

The College believes that the Administration's proposals must be evaluated in terms of their consistency with the direction for longer term reform that was charted in the Omnibus Budget Reconciliation Act of 1989. We share the view expressed by the Physician Payment Review Commission that "legislating sharp reductions in payment rates to take effect while we are

in the process of implementing a major reform of physician payment could make the achievement of the objectives of the reform more difficult."

We note that the Commission has indicated that the proposed elimination of the annual update in the Medicare Economic Index for 1991 for all services except primary care is a mechanism for meeting budget reduction targets that is consistent with payment reform. The College believes that continuing to strengthen support for primary care services while we proceed on the pathway to full implementation of an RBRVS system is an important signal to the profession regarding the Congressional commitment to this reform. Many physicians have expressed the cynical view that it the intent of Congress simply to reduce overvalued procedures, but not to increase support for those services that have been historically undervalued. Continuing past efforts to improve payment for primary care services would lessen this widespread fear that reform will be overtaken by cost containment. In addition, it will send an important message to those still in medical training regarding the implications of reform and will thereby enhance recruitment into the primary care disciplines.

We strongly support efforts to correct the technical problem which has surfaced for primary care services with regard to implementation of the 125 percent balance billing limit in 1991, the year before increases for these services are expected to occur under the fee schedule. It would be ironic, if the very services which Congress intended to increase under payment reform were inadvertently reduced and thereby penalized in the year prior to initiation of the increase. We urge that you continue to work to solve

this problem in a manner consistent with the overall objectives of payment reform.

With regard to overpriced procedures, prevailing charges were reduced substantially for 245 overvalued procedures in the Omnibus Budget Reconciliation Act of 1989. The prevailing charge in each geographic area was reduced by one-third of the amount by which it was estimated to be overvalued in comparison to the new Medicare fee schedule. We strongly support the view of the PPRC that substantial additional reductions should not be made, but that Congress complete the one-third reduction for those charges limited by last year's 15 percent provision.

It is important that successful implementation of the resource-based relative value fee schedule not be undone by extreme changes in payment policy.

Finally, before turning to next steps for payment reform, we want to highlight our concerns regarding funding of graduate medical education. This committee took the lead in 1985 on thoughtful and systemic reform of the financing of graduate medical education. It is important that this work not be undone by any rush to identify sources of budget savings. If this issue is to be revisited, it must be done so with care and full attention to the implications of any changes for the training of future physicians, for the maintenance of our hospital system, and for patient needs.

Next Steps in Medicare Physician Payment Reform

The College has long been an advocate of a payment system which sets appropriate levels of payment for appropriate services. The RBRVS-based fee schedule will help to assure appropriate payment. In approving creation of an Agency for Health Care Policy and Research, Congress took a major step towards building a federal government role in determining appropriate services. This committee can play a further role in this effort.

We have outlined our thoughts on some of these next steps more fully in previous testimony to the PPRC, but we would like to summarize them for the committee. The first task is to accelerate efforts to fully analyze the reasons for increases in expenditures in Medicare Part B. The present state of unexamined information with regard to expenditure growth conveys to some policy makers and others that the system is riddled with inappropriate use of services. We need to develop the information that will permit us to determine whether this is in fact the case. Through focused hearings, its charge to the PPRC, and its direction to HCFA, this committee can promote an examination of growth trends in Part B in as disaggregated and specific a fashion as possible.

For example, which components are growing most rapidly? What are the clinical and other explanations for these changes? Do they represent improvements in medical care or inappropriate use of services, or some of each? How can we tell the difference? Where do the data show that inappropriate services are concentrated? How much of the spending increase is accounted for by costs that do not directly relate to providing medical care? What is the role of changes in the locus of service delivery?

The second task, which we would argue must begin immediately, is to move forward with a fundamentally new way of reviewing medical necessity and utilization. Present efforts at utilization control appear to be failing. Current approaches are antagonizing the physician community. The anger generated by many utilization review requirements, by inappropriate second-guessing of professional judgment, by intrusion into the doctor-patient relationship, is felt by physicians who share with you Medicare's goal of providing cost-effective health care for elderly Americans.

We testified before you earlier this year in Atlanta, on problems being experienced by physicians in Georgia and elsewhere with the Medicare program. We will not repeat those points here, except to emphasize again, the urgency of addressing problems of utilization review, coding reform, and contractor management and to note the continuing nature of the problem in Georgia and elsewhere. We urge that you call for appropriate oversight by the Health Care Financing Administration of its contractors and subcontractors. We should indicate that we are pleased to see that the new Administrator of the Health Care Financing Administration has placed a high premium on identifying and implementing improvements in the management of the Medicare program and we hope that we see results from her initiative.

This committee can play a major role in documenting the failures of our present system and generating recommendations for major reform. The College believes that utilization review must move away from its current punitive approach and towards a model based on what has been characterized as the continuous improvement of medical practice. Such a system should be oriented toward what we know about how physicians change their behavior.

Physicians generally seek to practice like their peers, they want to be in the norm, as the Maine medical assessment work has shown, and they will respond when they see the norm evolving. We must foster a peer standard based on reliable, scientifically-generated information, and then utilize the community of physicians to fully disseminate this standard.

This is not to say the Medicare should give up the audit and inspection functions of utilization review, i.e., looking for the outliers. This must continue in order to assure fiscal integrity, but it cannot continue to be based on a case-by-case review of physicians' decisions. Rather, it should be done through the use of aggregate data on practice patterns that can flag aberrant behavior for further scrutiny.

Conclusions

Mr. Chairman, we recognize the difficult decisions facing this committee. We recognize that it is painful for you to find additional budgetary savings in programs which you strongly support and which have taken a disproportionate share of reductions in the past. Even as you take these short-term steps, we would urge you to work towards developing a comprehensive health policy that can end this disruptive annual cycle of budget-driven decisions. Some of the steps we have outlined today would help us to move in the direction of a restructured and improved Medicare program, and would lay the groundwork for comprehensive reform of the health care system.

We would close by noting again, in the strongest terms possible, our concern that the cumulative effect of past budget cutting efforts coupled with fiscal year 1991 cutbacks of potentially unprecedented magnitude, poses a direct and serious threat to the integrity, stability and ultimately the viability of the Medicare and Medicaid programs.

We must begin to move forward on long-term comprehensive reform of the health care system. If we fail to do so, we face continuing erosion of the basic infrastructure of health care facilities and personnel. We will witness the further attrition of physicians entering primary care medicine and the growing disillusionment of some of our best senior practitioners, resulting in practices being closed to Medicare and Medicaid patients and in early retirements from practice. Quite simply we will wake up one day and find that we know longer have the facilities or the personnel to meet the nation's needs. If we fail to take steps towards systemic reform we face the paradox of continuing cost escalation and growing numbers of uninsured and unserved citizens.

Again, we thank the Subcommittee for all of its past efforts to chart a reasonable path under difficult budgetary circumstances. We look forward to working with you towards further reform. I would be pleased to respond to any questions which you might have.

Mr. WAXMAN. Thank you very much.
Dr. Keith.

STATEMENT OF DONALD M. KEITH

Mr. KEITH. Thank you, Mr. Chairman.

I am Donald Keith, practicing family physician from Seattle, member of the Board of Directors and Chair of the Commission on Legislation of the American Academy of Family Physicians representing over 69,000 members.

Thank you for inviting me to share the Academy's views on the Medicare budget proposals.

I would like to take this personal opportunity to thank the subcommittee for your fine work during the first session of Congress in enacting Medicare physician payment reform. You developed a thoughtful package that addresses many of the concerns that Congress, the public and the medical profession have shared about the Medicare program.

However, in order for the benefits of the reform to be realized, the transition to and implementation of its four elements must be carefully managed.

We encourage you to monitor this process to ensure that implementation is done in a manner consistent with congressional intent and within the time frame specified in law.

We first wish to call to your attention and ask for assistance in addressing the notch problem which occurs as the payment reform package imposes balanced billing limits prior to the transaction to the fee schedule. The balanced billing limits in 1991 are the lesser of the physicians' 1990 maximum allowable actual charges, the maximum or 125 percent of the 1991 historical prevailing charge.

While the Academy certainly urges the congressional intent of the balanced billing limits included in the reform package, we are concerned about the impact of primary care services in 1991.

Under the 1991 limits historical prevailing charges are used as the base. Particularly in the case of primary care services, which tend to have low prevailing charges. This method results in a rollback of the balanced billing limits to levels below the maximum for those services. The practical effect of this provision is that physicians providing undervalued services slated for increases under the fee schedule beginning with the transition in 1992 will have to reduce their charges for these services in 1991. The impact of the provision is greater on primary care practices and practices in rural areas, as you have heard from the Physicians Payment Review Commission.

We encourage your consideration and support of a mechanism to modify the policy for 1991 so that physicians who will receive increases under payment reform are not required to charge below what they currently are allcwed to charge.

Various proposals have been suggested, including the floor on the prevailing charge limits for primary care services, delay implementation of this provision for 1 year and, therefore, retaining the 1990 MAAC's, delaying implementation for 1 year only for primary services and increasing for 1 year the balanced billing limit for only primary services.

The Physician Payment Commission and the Congressional Budget Office have studied the impact of the various options. The AARP encourages you to enact any alternative that will address the problem in a way that achieves the results which are consistent with the intent of the physician payment reform package.

As outlined in my written statement, the Academy cautions against further changes in Medicare physician payment, including significant budget reductions in fiscal year 1991 that could alter the progress made towards achieving reform in Medicare payment policy. Any modifications in the program should be consistent with and assist rather than hinder the transition as an example of the proposed increase in the MEI for primary care services.

With respect to clinical laboratory services, the administration proposes a savings of $60 million by reducing the fee paid for clinical laboratory services. This comes at a time when stringent requirements for previously unregulated labs are under consideration, requirements that are anticipated to create considerable additional costs for physician office laboratories. These costs coupled with fee reduction could create significant hardships, ultimately diminishing the number of laboratories.

Over 23,000 family physicians whose testing would be considered to be level 2, and, therefore, subject to onerous personnel requirements, may find it impossible to meet the HCFA requirements. Access to quality lab care is jeopardized.

We understand the budget summit negotiators are considering an additional Medicare proposal for a 5 percent Medicare differential for board certified physicians, except in rural areas. There is no demonstrated different in quality of care in the medical literature between board certified and not board certified physicians, and to differentiate in this way violates the spirit of payment reform which provides payment for services in the resources-based fee schedule regardless of physician specialty.

Further, if this proposal is advocated because of a belief that the quality of care is higher when provided by board certified physicians, it is inconsistent to exempt rural areas. We urge you to strongly oppose this because it is inconsistent with physician payment reform using a resource-based fee schedule.

A further schedule under discussion apparently would impose a fee of $1 for every paper claim filed. Physicians are already burdened by the provision that they must file all Medicare claims for beneficiaries. The additional charge is unwarranted.

Primary care physicians must file for every office call service which charges per patient unit of one-tenth to one-one hundredth of those physicians who are proceduralists. This provision would be disproportionately harmful to the primary care physicians. This will disproportionately hurt physicians over 40 and those in rural areas who have a much lower rate of computer use in their practices.

The Academy strongly opposes this measure.

Thank you very much.

[Testimony resumes on p. 115.]

[The prepared statement of Dr. Keith follows:]

STATEMENT OF AMERICAN ACADEMY OF FAMILY PHYSICIANS

I am Donald M. Keith, M.D., a member of the Board of Directors and Chair of the Commission on Legislation and Governmental Affairs of the American Academy of Family Physicians, the national medical specialty society representing over 69,000 practicing family physicians, family practice residents and medical students. Thank you for inviting me to share with you today our Academy's views regarding budget issues related to the Medicare program.

I would first like to thank the members of this subcommittee for your exemplary work during the final hours of the first session of the 101st Congress to accomplish passage of Medicare physician payment reform. The package that you and your colleagues on the Ways and Means Committee and the Senate Finance Committee crafted represents a thoughtful approach to addressing many of the concerns that Congress, the medical profession and the public have shared about the Medicare program. You in Congress designed a comprehensive reform package, which includes a rationalized pricing system, limits on balance billing, a means for addressing overall Medicare expenditures and a program expanding outcomes and effectiveness research. The new law holds the potential for providing greater equity in physician payment, financial protection for beneficiaries, a measure of control in the growth of Medicare expenditures and support for improving the knowledge base on which clinical decisions are made.

Family physicians are encouraged that when fully implemented the new fee schedule should more accurately and appropriately value services, should eliminate troublesome specialty differentials and moderate the significant

disparities in payment between urban and rural areas. Furthermore, one of the major benefits of the new fee schedule may be its influence on medical specialty and practice location choice, encouraging more students to choose primary care specialties and practice in rural and other underserved localities. This approach ultimately will benefit patients by providing greater access to many essential primary care services.

However, in order for the benefits of the reform to be realized and the integrity of the package preserved, the transition to and implementation of the four elements must be managed carefully. We encourage this subcommittee to monitor this process to ensure implementation is done in a manner consistent with Congressional intent and within the time frame specified in law.

1991 Balance Billing Limits:

We first wish to call to your attention and ask for your assistance in addressing the "notch" problem which occurs as the payment reform package imposes balance billing limits prior to the transition to the fee schedule. The balance billing limits in 1991 are the lesser of the physician's 1990 maximum allowable actual charge (MAAC) or 125 percent of the 1991 historical prevailing charge. While the Academy certainly understands the Congressional intent of the balance billing limits

included in the reform package, we are concerned about the impact on primary care services in 1991. Under the 1991 limits, historical prevailing charges are used as the base. Particularly in the case of primary care services which tend to have low prevailing charges, this method results in a rollback of the balance billing limits to levels below the MAACs for those services. The practical effect of the provision is that physicians providing undervalued services slated for increases under the fee schedule beginning with the transition in 1992 will have to reduce their charges for these services in 1991.

The impact of the provision is greater on primary care practices and practices in rural areas according to the Physician Payment Review Commission (PPRC). According to simulations by PPRC, 12 percent of primary care practices would experience reductions up to 5 percent of Medicare revenues. In rural areas 19 percent of practices will have revenue declines of up to 5 percent. Visits constitute the largest proportion of the affected services. After 1991 the limit is tied to the fee schedule amount and the provision is less onerous; however, for 1991 reductions of 5 percent or more could have a substantial impact for those practices which already are having financial difficulties due to historical reimbursement inequities and those which provide services to a large Medicare population.

We encourage your consideration and support of a mechanism to modify the policy for 1991 so that physicians who will receive increases under payment reform are not required to charge below what they currently are allowed to charge. Various proposals have been suggested including increasing the floor on the prevailing charge limits for primary care services, delaying implementation of this provision for one year, thereby retaining the 1990 MAACs as the balance billing limit, delaying implementation of this provision for one year only for primary care services, and increasing for one year the balance billing limit for only primary care services. The Physician Payment Review Commission and the Congressional Budget Office have studied the impact of the various options. The AAFP encourages you to enact any alternative that will address the problem in a way that achieves results which are consistent with the intent of the physician payment reform package.

Medicare Volume Performance Standard:

We next wish to call to your attention a potential problem with respect to implementation of the Volume Performance Standard for surgical services. Integral to physician payment reform is an effort to control overall expenditures for physician services. The dual mechanism for accomplishing this is to utilize Volume Performance Standards in determining the annual update in physician fees. The law provides for separate targets by

category of physician services, a concept supported by the Academy. Actual performance relative to the standard may vary by type of service, and this information will be used in determining the update, providing incentives for desired physician behavior, that is to provide more or less of certain services. We strongly believe that in order to accomplish this policy objective performance standards should be set for services, rather than by the specialty of the physician providing the service. For example, the volume performance standard set for FY 1991 for surgical services should apply to services, rather than to surgeons as a specialty, as surgical services are provided by several different physician specialties.

However, HCFA announced in the Federal Register of May 3 that in setting separate targets for surgical services that the decision was made to distinguish surgical services performed by surgeons, using the carrier payment record. The physician specialty is self-designated, and carrier designation determines which surgical services will be included, rather than an explicit policy using CPT codes. Narrowly defining surgical services as those which are performed only by surgeons means that at least 20 percent of surgical services, according to HCFA estimates, will be excluded from the definition. Additionally, does not the approach being contemplated enable those who perform surgery to determine whether the volume performance standard for "surgeons" is more or less generous than

the standard for "non surgeons" and designate their specialty accordingly? We believe the answer is yes.

The policy is in variance with both the law and with good public policy. The law includes the authority for a separate standard for surgical services, and calls for the elimination of specialty differentials. However, if implemented as noted above, the MVPS for surgeons could result in a separate update for surgical services provided by a defined set of physicians, essentially a specialty differential in Medicare payment. You may be aware that the Department of Health and Human Services was involved in litigation relative to its policy of specialty differentials and as a result eliminated these differentials in several states, including Michigan and most recently Tennessee. We fail to understand the rationale for HCFA's promulgation of a new policy of specialty differentials in view of the loss on this issue in the courts and the provision of PL 101-239 prohibiting such differentials.

We would now like to discuss with you several of the Medicare related proposals included in the Administration's budget. We are concerned that further changes in Medicare physician payment at this time could alter the progress made to date. Any modifications in the program should be consistent with and move in the direction of the reform package and

facilitate rather than hinder the transition, as is the case with the proposed increase in the MEI for primary care services. However, many of the proposals included in the Administration's budget give rise to significant concern. The Academy's views on selected aspects of the budget proposal are outlined below.

Reduction in Payments for Overvalued Procedures:

The administration's proposed reductions in payments for procedures that are overvalued in relation to the estimated resource-based fee schedule violate the spirit of physician payment reform by failing to address undervalued services. Any reductions in payment should be balanced by increases in payment levels for undervalued services. To do otherwise is inconsistent with and threatens the viability of payment reform. As noted on our comments in regard to balance billing limits, changes in Medicare payment during 1991 should be consistent with the payment reform package.

Reduction in Payments for Overvalued Localities:

In proposing only reductions in payments for procedures in localities where payments exceed the national average, the administration's proposal has fallen prey to the same flaw in logic evidenced in the overvalued

procedure cuts. Reducing payments in some areas while failing to address the perversely low payments in other, mostly rural areas perpetuates the access problems faced by rural beneficiaries.

Of additional concern regarding reduced payments in overvalued localities is the use of the existing geographic practice cost index (GPCI) to adjust for alleged geographic differences in practice costs. Our analysis of the GPCI indicates that it is significantly flawed and that it provides an entirely distorted picture of relative practice costs. We are unaware of any data supporting the conclusion that geographic differences in practice costs exist. In fact, if any conclusion is to be drawn from practice cost data, it is that rural practices are slightly more expensive than urban practices, which is opposite to the conclusion reached by the GPCI. I would remind the subcommittee that in OBRA 89 Congress adopted a provision calling upon the Physician Payment Review Commission to study the extent to which practice costs vary geographically and the extent to which the available GPCI accurately reflects practice costs. At a minimum I urge you to avoid using the GPCI before the studies that you have requested are completed.

Phase-in Increases for New Physicians:

Congress previously limited fees for new physicians for two years, at 80 and 85 percent of the prevailing charge levels. Given the historical inequities in calculation of Medicare physician fees, these limits

prevented new physicians from entering practice and receiving payment significantly greater than established physicians practicing in the same locality. However, the new proposal would limit payment for new physicians over a five year period, and extend this policy under the new fee schedule. We strongly object to this provision. A principal purpose for developing the new fee schedule is to rationalize payment. Once an appropriate fee for each service is determined, we believe it imperative that Medicare recognize the fee for all physicians providing the given service. We believe it inappropriate to arbitrarily prohibit licensed physicians providing a service from eligibility to receive the payment determined to be rational and appropriate for the particular service, and urge you to reject this proposal as inconsistent with the intent of payment reform.

Assistants at Surgery:

The proposed budget calls for paying the same amount for a surgical procedure regardless of whether or not the primary surgeon elects to use an assistant. Only limited exceptions would be allowed. The rationale cited for this proposal is based on the wide geographic variation in the use of physicians as assistants at surgery and in the use of primary care physicians. The proposal would create a disincentive for a physician to provide assistance at surgery and for a surgeon to utilize an assistant.

It would encourage surgeons to select assistants who are nurses or hospital staff paid by the hospital because only then could the surgeon keep the entire fee.

Individual situations often require that there be another physician actively participating in the patient's surgical care. Primary care physicians serving as assistants are in a position to recognize that there are unique circumstances surrounding a patient's surgery and the operative complications that may arise. Family physicians are particularly qualified to provide this assistance because of their knowledge of their patients' medical history and the existence of multiple conditions that might complicate a procedure. Family physicians bring to the operating room more than just the technical ability to assist at surgery.

Clinical Laboratory Services:

The administration proposes saving $60 million by reducing payment for clinical laboratory services to 90 percent of the median fee schedule amounts for non-profile tests and 80 percent of the median for profile and standardized tests. Fees above the limit would receive no update in 1991. We would urge extreme caution in fee reductions for clinical labs at this time. Clinical laboratories in locations previously unregulated will soon be required to meet stringent regulatory requirements that

threaten the viability of a number of laboratories. For example, over 23,000 family physicians perform testing that under regulations proposed in May is categorized as Level II, which includes stringent personnel requirements that will be impossible for family physicians to meet. The regulations are anticipated to create considerable additional costs for physician office laboratories. These costs coupled with the proposed reduction in fees could create significant hardships. We are very concerned that the number of laboratories may be severely diminished, which would threaten patient access to quality laboratory services.

Reduction in Capital and Outpatient Payments to Rural Hospitals:

Because nearly thirty percent of family physicians practice in rural communities, we share the concern expressed by many of the members of this subcommittee about the plight of rural hospitals. Rural hospitals do not have a sufficient volume of cases in each DRG to achieve the "averaging" necessary to survive under PPS. As you are well aware, the typical rural hospital is experiencing a negative margin on its Medicare business. The loss of a rural hospital can mean the loss of all community-based health care. The failure of Medicare to pay its full share of capital costs in rural hospitals aggravates an already parlous situation.

We are particularly concerned about the administration's proposal to reduce by 10 percent payment for certain hospital outpatient services and to

reduce by 15 percent capital payments for outpatient services in all but sole community hospitals. The administration's proposed outpatient cuts will disproportionately affect rural hospitals, which generate a greater proportion of their Medicare income from outpatient services than do urban hospitals. A primary goal of PPS was to encourage the movement of inpatient care to the outpatient setting whenever that could be accomplished without a decrement in quality. The increase in expenditures for outpatient care should be regarded as an expected result and a sign of the program's success.

In addition, the reductions in payment for outpatient services may also have a negative impact on ambulatory-based graduate medical education programs, as noted below.

Changes in Medicare Graduate Medical Education Payments:

The budget proposes changes in two areas relating to Medicare graduate medical education payments. The first relates to the factor used in making indirect medical education payments to teaching hospitals. The proposal would reduce the IME factor from 7.7 percent to 4.05 percent. This proposal would seriously jeopardize many family practice residency programs. With their emphasis on primary care services provided in an ambulatory setting, these teaching programs tend to have costs associated

with their training that differ from inpatient based programs. The Institute of Medicine identified some of the factors contributing to the relatively higher costs of ambulatory training compared to inpatient training such as the need for additional space.[1] As reductions in the Medicare indirect GME payment cause hospitals to evaluate their commitment to medical education programs, we are concerned that ambulatory-based primary care residency programs such as family practice will become less attractive to hospitals.

Similarly, we are concerned about the impact of the proposed "reform" of direct GME payments. The proposal would establish a per resident payment derived from the national average of FY 1987 resident salaries updated by the CPI, with primary care residents weighted at 180 percent of the per resident amount. The proposal would, by basing the payment on salaries alone, disregard the other important elements of direct costs of graduate education presently recognized by the Medicare program, such as faculty, classroom and other costs. While the suggestion of a higher weighting factor for primary care programs is attractive, the recalculation of direct costs would result in a significant payment reduction to teaching hospitals. The anticipated effect, given the financial fragility of primary care teaching programs, would be a threat to their viability as the Medicare revenues to teaching hospitals are further diminished.

---

[1] Primary Care Physicians: Financing Their Graduate Medical Education in Ambulatory Settings. A report of a Study of the Institute of Medicine, Division of Health Care Services. National Academy Press, Washington, D.C. 1989. p. 2-3.

Medicaid:

While this statement has focused primarily on Medicare related issues, I want to take the opportunity to briefly discuss the Medicaid program, specifically as it relates to access to care.

The Academy is increasingly concerned about access to care by the millions of uninsured children and adults and believes that a strategy to provide insurance to this population should include expansion and reform of the Medicaid program. We believe that necessary changes in the Medicaid program must include uniform eligibility levels, a uniform essential benefit package, and payment levels that are consistent with Medicare payment using the resource-based fee schedule. The Academy supports efforts of the Physician Payment Review Commission to examine the Medicaid program and looks forward to working with PPRC and Congress to develop approaches for reforming this program and to develop a plan, utilizing Medicaid as a component for providing access to insurance for all Americans.

Summary:

The American Academy of Family Physicians strongly supports reform of Medicare physician payment recently enacted by Congress. We believe that

implementation of this plan will result in a greatly improved Medicare payment system -- improved from the perspective of Congress, beneficiaries and physicians. However, we must ensure that the transition to and implementation of the plan are consistent with the comprehensive reform enacted by Congress. To achieve this goal, the "notch" problem of the balance billing limits in 1991 require Congressional attention. Further modifications to Medicare payment and policy must be consistent with the reform in order to preserve its integrity. We urge this subcommittee to reject Medicare budget proposals that would disrupt the positive action taken by Congress. We further caution against additional changes in Medicare payment to hospitals that would jeopardize primary care education and impede access to care.

Thank you again for the opportunity to share the views of the American Academy of Family Physicians. We look forward to working with you as we move toward an improved Medicare program.

Mr. WAXMAN. Thank you very much, Dr. Keith.

We are being summoned to the floor for a House vote. So why don't we respond to that vote and come right back and proceed with questions.

[Brief recess.]

Mr. WAXMAN. Dr. McAfee, in considering the effect of the 1991 balance billing limits, has AMA looked at options other than a postponement of their implementation for 1 year? More specifically, have you taken a position on the proposal recommended by the PPRC to raise the floor on prevailing charges for primary care services?

Mr. MCAFEE. We have looked at that, Mr. Chairman, and as you probably know, our suggestion that we do favor is the postponement for 1 year. The effect—Dr. Keith mentioned it, the notch effect we happen to call the yo-yo effect, it is the same thing that would happen if you implement this at this time. It would take the highest cut to those physicians are trying to protect, those rural physicians prior to the implementation of the RBRVS. That is why we think it would defeat its own purpose by so doing.

For 1 year period, which seems to me a relatively short period of time, to implement this to us almost is a draconian measure that it wouldn't work out.

I do have something I could leave with the committee that shows that would happen from the 1991-92.

Mr. WAXMAN. So you have no position on the PPRC proposal?

Mr. MCAFEE. No, we have not.

Mr. WAXMAN. You have one you prefer but don't have a position on the other?

Mr. MCAFEE. That is correct.

Mr. WAXMAN. Your testimony indicates that the AMA believes that any reductions in Medicare should be in proportion to actual outlays. You indicate that in 1989 Medicare outlays for physician services represented by 27 percent of the total spending, so Medicare reduction target of $3 billion will yield about $800 million in savings from payments to physicians.

Has the AMA identified specific cuts that could be made to meet such a target?

Mr. MCAFEE. We have looked at a variety of areas that have been suggested and have been part of the administration's budget where specific areas might be reduced. Again, given the timing, the implementation of the RBRVS, we feel it is fairer than what has characterized the whole process to this point, that if cuts are necessary that they be equitably made across the board, both part A, part B, until the RBRVS is implemented. Then, you can control that by the conversion factor as to what you need to do.

Mr. WAXMAN. Dr. Ebert, the College of Surgeons recommends a full update for all physician services in 1991. In view of the expected change in the value of many surgical services under the new Medicare fee schedule beginning in 1992, wouldn't the differential update for services make the transition to the fee schedule less abrupt and disruptive?

Mr. EBERT. Mr. Chairman, I think the difficulty is it is going on the assumption that every surgical service will be so-called over

valued and reduced by a RBRVS. Much of that has not—the study hasn't been concluded as yet.

I think if one had to take a intermediate position, it would be logical to say don't give MEI update for services that are currently considered over valued but I think that it puts an undue burden on many services that may even be undervalued by the RBRVS that surgeons perform.

Mr. WAXMAN. In the testimony of the PPRC, they set forth three possible approaches to assure appropriate use of assistance in surgery, peer review, physician profiling and prior approval by carriers.

Which, if any, of these options does the college support?

Mr. EBERT. The second one is probably the one we would support the most. We believe that we should support the surgeons who needs an assistant in the type of surgery that should be done and with new bookkeeping methods and data file that HCFA will have. It is very easy to profile a surgeon and the use of an assistant versus a particular code. We certainly would not support the idea of prior authorization.

I think the harassment issue is so bad today and the number of phone calls someone has to make, that there is unlikely to be any logical savings. I think by longitudinally looking at surgeons you would get a certain amount of peer pressure to reduce the frequency when it was not necessary.

Mr. WAXMAN. With respect to the so-called overpriced procedures, what is the college's position on the disability of completing the full one-third reduction of the amount such charges exceed estimates of the proposed fee schedule?

Mr. EBERT. I certainly think last year I think you were in the range of 15 percent and certainly the farther it could be stretched over a number of years the more logical it seems.

We are still concerned that until that RBRVS is finalized and one actually sees what the numbers are, I am not so certain that anyone knows whether something is truly one-third over valued or not.

I think it will be very possible that you may well overshoot on some of these reductions.

Mr. WAXMAN. Dr. Davies, your statement indicates that physicians are closing their practices and countless patients are going unserved.

Has the ACP gathered any data on the numbers of closed practices and which closures can be attributed to Medicare physician payment cuts?

Mr. DAVIES. Not formally, no, sir. We have not done that.

I must say, as a practicing physician, in my own hospital I have done informal surveys and my estimate is that 75 percent of younger physicians do not take new Medicare patients. The older physicians seem to take more of them. I think they have more compassion, realizing that pretty soon they will be there with them.

But quite seriously, this is an enormous problem and it is getting worse. There is no question. Whether it is anecdotal or not it is a very real problem.

Mr. WAXMAN. Do you think the younger physicians take more Medicaid children because they have a closer identification with that end of the spectrum?

Mr. EBERT. Perhaps.

Mr. WAXMAN. Unlikely.

I appreciate the emphasis in your testimony on the importance of more rigorous analysis of experience in the Medicare program and the need to find more cost-effective ways of managing the program and I share your hope about potential benefits of medical effectiveness, research and practice guidelines.

Do you believe that dissemination of appropriate scientifically based practice guidelines will be sufficient to achieve cost containment goals or must we apply such tools in determining whether and how much to pay for care?

Mr. EBERT. I think that is certainly the way to begin. Whether or not it will work remains to be seen. At some point it may well be that some sort of reimbursement mechanism will have to be tied to the practice guidelines.

But initially, at least, we would certainly go for having good guidelines well done, well thought out, well designed and see how they work.

Mr. WAXMAN. Dr. Keith, you mentioned a number of options to moderate the impact of the 1991 billing limits on primary care services.

Could you tell us which approach the Academy prefers?

Mr. KEITH. Any of those would do the job.

Looking at the problem, though, it is really a narrow problem, not a broad problem. So I think the solution should be a more narrow solution, a continued increasing of the floor on prevailing charge limits for primary care services would be the narrowest way to take care of the problem.

Mr. WAXMAN. I would like for you to comment further on establishment of separate Medicare volume performance standards for surgical services and for other physicians services. It is my understanding that data limitations in the Medicare claims file largely have determined the policy of HCFA in setting the volume standard for surgical services.

Can you elaborate on this point?

Mr. KEITH. The concern that we had was that the volume performance standards should be for a service rather than a specialty. We feel that a volume performance standard for different types of services, therefore, could be an educational type of thing that more or less type of services could be provided.

If, in fact, the volume performance standard was a surgeon as opposed to a nonsurgeon there would be a certain percent, 20 percent not done by surgeons per se. We had the concern that then we would go back to specialty differentials which the law specifically forbade.

Mr. WAXMAN. Dr. Ebert, do you want to comment on that?

Mr. EBERT. The college's position has been that if volume performance standards or any type of quality review is going to work, it would have to be done by true peers within the profession. We recognize there are some overlapping areas. Unfortunately, the term "surgery" is used rather broadly many times and we actually

take the true meaning of surgery at the college reviews rather than diagnostic procedures, then, I think that to have any influence to decide that something is truly necessary you are going to have to have it reviewed by a professional society.

We think we would have little leverage on nonsurgeons doing surgery or nondiagnostics, which very often are coded in the CPT code as surgery.

Mr. WAXMAN. Dr. Keith, thank you for your support for Medicaid reforms. I think they are very important. I appreciate your raising that.

Thank you very much for your testimony, gentlemen. We look forward to working with you on this whole issue.

In recent budget reconciliation legislation, we made a series of modifications to the payment policies for the services of anesthesiologists and radiologists under Medicare. Further changes have been recommended for these services by the President's budget and the PPRC.

Our next panel includes representatives of two organizations, including physicians practicing in these specialties.

First, Dr. Betty P. Stephenson, president-elect of the American Society of Anesthesiologists and a practicing anesthesiologist from Houston, TX. She will be followed by Dr. Lee F. Rogers, chairman of the board of chancellors of the American College of Radiologists.

I want to thank you both for being here. Your statements will be in the record in full.

We would like to ask you to limit your oral presentation to no more than 5 minutes.

STATEMENTS OF BETTY P. STEPHENSON, PRESIDENT-ELECT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS; AND LEE F. ROGERS, CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY

Ms. STEPHENSON. Thank you, Mr. Chairman.

The administration proposes two reductions for anesthesiologists, 10 to 25 percent reductions in conversion factors, and a 35 to 50 percent reduction in medical direction payments.

ASA is committed to working with the subcommittee to achieve reasonable savings but as a society we oppose the administration's proposals.

In March of this year, our leadership discussed alternatives and brought them to the Congress and PPRC. We committed to supporting a 4 percent reduction in anesthesia payments and an extension of the current law reduction in medical direction payments.

These proposals are also supported by PPRC and represent annual savings of approximately $65 million.

Anesthesiologists are paid on a relative value scale where units of service are multiplied by a dollar conversion factor. The ASA value guide using base and time units has been recognized as a resource base by the Congress and PPRC.

The administration proposes a reduction in the national average conversion factor by 10 percent with a maximum reduction of 25 percent. ASA supported last year's RBRVS package with the un-

derstanding that the approximate 18 percent reduction for anesthesia services would be phased in over a 4 year transition.

It is inappropriate and unacceptable for the administration to seek more than half of the reduction in 1 year. The impact on individual physicians is too much and would undermine the goals of RBRVS.

The proposed ceiling of 25 percent is far too high. One must remember that this would apply to every anesthesia procedure for Medicare patients. This is quite different than picking out one procedure of the many a physician might provide and calling it over valued.

PPRC supports ASA's contention that a 10 to 25 percent cut is excessive for a single year and recommends an average 4 percent geographically adjusted cut with the 15 percent maximum.

ASA agrees with this approach. If this proposal is considered as early transition to RBRVS, then this reduction appropriately represents approximately one-fifth of the likely RBRVS reduction for anesthesiology.

Since approved changes for anesthesiologists are $1.2 billion annually, a 4 percent reduction provides $50 million in Medicare savings.

Let me add here that we should get full credit for these savings, not the 50 percent often allowed by OMB and CBO, anesthesiologists don't gain volume in response to reduced revenues. Our responsibility is supplying anesthesia service in response to surgery schedules.

Let me turn to the payments for medical direction. This affects 70 percent of our members that practice in the anesthesia care team mode. ASA supported a 1987 initiative of this subcommittee to reform payments to those providing medical direction by reducing the base unit values for concurrent procedures. This will expire in December of this year.

ASA is opposed to the administration's proposal which would mean cuts of 35 to 50 percent for many of our members.

We do support the PPRC recommendation that the existing base unit reductions be extended beyond this December. This will provide savings of approximately $15 million annually and is a proven policy that will not disrupt the anesthesia team approach.

Finally, ASA is concerned about the impact of the 1991 balance billing limits particularly affecting those anesthesiologists in historically underpaid areas. We join with AMA and other specialities in seeking a 1 year delay of the 1991 limits.

We are ready to work with you as this difficult budget cycle proceeds. We feel that as physicians, citizens, we should assume some responsibility in addressing the deficit.

We believe the proposals that have been outlined will provide significant savings, $65 million for fiscal year 1991, in a manner that will not disrupt or jeopardize the delivery of good anesthesia care.

Thank you.

[Testimony resumes on p. 130.]

[The prepared statement of Dr. Stephenson follows:]

STATEMENT OF THE

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Thank you Mr. Chairman. I am Betty P. Stephenson, M.D., President-Elect of the American Society of Anesthesiologists (ASA). I am in the private practice of anesthesiology in Houston, Texas. We as a specialty society are pleased to appear before the Subcommittee today to discuss Medicare Part B payment proposals for the Fiscal Year 1991 budget.

The Administration proposes two inequitable and severe reductions for anesthesiologists: a 10 - 25 percent reduction in conversion factors and virtual elimination of medical direction payments. The ASA must oppose these reductions, but we are committed to working cooperatively with the Subcommittee to achieve reasonable savings.

As early as last March, the ASA leadership discussed two alternative savings proposals and brought them to the Congress and the Physician Payment Review Commission (PPRC). It is never easy to support reductions, but the Society is committed to support the savings proposals outlined in this testimony: a 4 percent aggregate reduction in anesthesia payments and the extension of current law reductions in medical direction payments. These proposals are supported by the PPRC.

I would like to describe our objections to the Administration proposals and to explain the alternative proposals designed to achieve budget savings.

Framework for Savings and the RBRVS

As the Subcommmittee is aware, anesthesiologists have historically been reimbursed on a relative value system. The ASA Relative Value Guide (RVG) uses base units, which describe the risk, skill and complexity of an anesthetic procedure, and time units, which measure the actual time spent in providing care. The RVG has been recognized as a valid, resource-based methodology by the Congress and the PPRC. Initiatives taken by this Subcommittee in the past have considered the RVG as the appropriate framework for payment reform:

- OBRA '86 ratified HCFA regulations cutting the base units for cataract anesthesia from 8 units to 4 units. Five-year savings: $405 million.

- OBRA '87 mandated reductions in base units for those anesthesiologists medically directing certified registered nurse anesthetists. Three-year savings: $35 million.

- OBRA '87 mandated that all Medicare carriers use a uniform Relative Value Guide for anesthesia services (budget neutral).

- OBRA '89 mandated that anesthesia time be counted in actual minutes, rather than being rounded up to the next whole 15 or 30 minute unit. Five-year savings: $245 million.

- OBRA '89 directs the Secretary to use the uniform Relative Value Guide under the new Medicare Resource Based Relative Value Scale (RBRVS), but to adjust the conversion factors to be consistent with the goals of the RBRVS.

Administration Proposal - Reductions In Anesthesia Payments

The Administration proposes to reduce a national average anesthesiology conversion factor by 10 percent, with a maximum reduction for any carrier area of 25 percent. Such reductions are too radical, both as to the aggregate 10 percent cut and the unreasonable maximum cut of 25 percent. Further, the rationale for such drastic cuts is purely budget-driven, without regard for the RBRVS.

ASA supported the landmark RBRVS package last year with the understanding that the anticipated reductions for anesthesia services would be phased in over the four year transition, as scheduled by the legislation. Total reductions for anesthesiology under the RBRVS are expected to be approximately 18 percent. It is inappropriate for the Administration to seek more than half of that reduction in a single year. Such a cut would pose economic dislocations for anesthesiologists, and would undermine the redistributive goals of RBRVS.

The proposed ceiling of 25 percent is unreasonably high because we are not dealing with one "overvalued" procedure among many services which a physician may provide. The proposed cuts would be applied to every anesthetic given to a Medicare patient without a determination that any of the procedures are overvalued. There is neither precedent nor justification for a cut of such magnitude; we believe it carries the risk of severe dislocation in the pattern of anesthesia care for Medicare

patients, as individual anesthesiologists or groups in the high pay areas respond to a radical cut in Medicare reimbursement levels.

ASA Position

The Physician Payment Review Commission recently submitted its recommendations for the FY 1991 budget to the congressional health subcommittees. The Commission stated:

> The Administration's proposed reductions for anesthesia and radiology appear to be too large for a single year. These proposals would reduce payments for virtually all of the services provided by anesthesiologists, so the impact on practice revenue would be greater than that resulting from reductions for overvalued procedures. The Commission recommends a 4 percent, geographically adjusted cut, with a 15 percent maximum cut.

ASA does recognize the need for deficit reduction and agrees with PPRC's approach to find alternative savings in a manner consistent with RBRVS implementation. The Administration's concept of a geographically-adjusted sliding scale reduction certainly can be retained, but we would ask the Subcommittee to consider rational reductions reflecting sound policy and realistic numbers.

Therefore, ASA proposes that payments to anesthesiologists (conversion factors) be reduced an aggregate 4 percent; no locality would be reduced more than 15 percent; and those localities below the reduced national average would not be cut in 1991. The 4 percent reduction should be adjusted by the geographic practice cost index (GPCI) in order to be consistent

with RBRVS. ASA has prepared an analysis of the impact of this proposal in every carrier area, and provided this information to Subcommittee staff.

According to recent HCFA data, approved charges for anesthesiologists are $1.2 billion annually. A 4 percent reduction provides $50 million in Medicare savings.

When one considers this proposal as early transition to the RBRVS, then the appropriate level of reduction and geographic adjustments build on the existing physician payment reform policy and there is some basis for the amount of the reduction:

- anesthesiology would undergo a five-year transition period to full RBRVS implementation, rather than the four years provided in OBRA '89;
- the 4 percent reduction, therefore, appropriately represents about 1/5 of the anticipated RBRVS reduction for this specialty;
- the cut would be adjusted by the HCFA geographic practice cost index (GPCI);
- carrier areas below the "geographically-adjusted" conversion factor would not be cut in order to protect low-pay areas;
- 15 percent would be the maximum cut for any carrier area.

Reductions and geographic adjustments to the existing carrier prevailing conversion factors is consistent with both OBRA '89 and recommmendations of the Physician Payment Review Commission: the ASA Relative Value Guide, accepted by HCFA, is resource based and will be retained under RBRVS, with appropriate adjustments to the conversion factors. In 1992 and thereafter, RBRVS transition would proceed as provided for in OBRA '89.

I would like to bring to your attention the need for anesthesiologists to receive full credit for savings proposals. We do not agree with OMB's and CBO's tendency to discount savings by as much as 50 percent, supposedly to account for physicians' gaming the system. Anesthesiologists have no opportunity to increase the volume of services in response to reduced revenues -- we simply cannot go out and find more people to anesthetize. The full savings, therefore, should be counted toward deficit reduction.

Medical Direction Services

Approximately 70 percent of anesthesiologists provide care working with CRNAs in the anesthesia care team mode of practice. ASA supported a 1987 initiative of this Subcommittee to reform payments to anesthesiologists providing medical direction by reducing the base unit values for concurrent procedures by 10 percent in the case of two concurrent procedures, 25 percent in the case of three concurrent procedures, and 40 percent in the case of four concurrent procedures. In addition to base unit reductions, only one-half of the time units are recognized in medical direction payments.

36-375 0 - 90 - 5

Administration Proposal

The Administration proposes to sharply reduce payments for anesthesiologists' working with certified registered nurse anesthetists (CRNA) by limiting the medical direction fee to th difference between the payment if the anesthesiologist had personally performed the service and the Medicare payment to th CRNA. The Administration further proposes that the payment to the CRNA shall not be reduced.

ASA is opposed to this radical reduction in medical direction payments. This proposal would mean reimbursement reductions of 35 to 50 percent for anesthesiologists who do not employ the CRNAs they medically direct. This Medicare payment policy would, by providing such a perverse incentive, dictate employment relationships.

We take the strongest objection to the Administration's statement that its proposal would not only reduce "excessive payments" but treat more fairly "anesthesiologists who do their own work, rather than medically directing others doing it." The anesthesiologists' medical involvement, judgment, and responsibility are not assumed by others. The Medicare payment regulations and ASA's official guidelines delineate clearly the functions an anesthesiologist must provide in order to be reimbursed for medical direction. The anesthesiologist must:

- perform a pre-anesthesia examination and evaluation;
- prescribe the anesthesia plan;
- personally participate in the most demanding procedure in the anesthesia plan, including induction and emergence;

- ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

- monitor the course of anesthesia administration at frequent intervals;

- remain physically present and available for immediate diagnosis and treatment of emergencies; and

- provide indicated post-anesthesia care.

Conformity to these guidelines requires significant personal involvement by the anesthesiologist in each case, but nonetheless permits the simultaneous availability of medical skill and judgment in more than one operating room.

ASA Position:

With regard to the Administration's proposed medical direction cuts, the PPRC recommends:

> As an alternative to the Administration's proposal, the Commission suggests that Congress extend an OBRA '87 provision that reduced payments to teams of anesthesiologists and CRNAs according to a sliding scale... Since this provision expires at the end of 1990, an extension of it would produce budget savings while allowing the Commission time to complete its study of non-physician providers.

ASA supports extending the current law mandating reductions in medical direction payments, which is due to expire on December 31, 1990. This is proven policy that will yield at least $15 million in annual savings. Further, extension of current law would provide savings in a manner that would not disrupt the delivery of anesthesia care or impose drastic reimbursement changes.

The PPRC is to report to the Congress in July 1991 regarding the treatment of non-physician Part B providers under RBRVS, and this discussion of CRNA services will necessarily deal with medical direction. Substantive changes this year involving any aspect of the anesthesia care team would be premature and counterproductive.

1991 Balance Billing Limits

Finally, ASA is very concerned about the impact of the 1991 balance billing limits, particularly on those anesthesiologists practicing in historically underpaid areas. We join with the AMA and the other specialty societies in seeking a delay of the 1991 limits until 1992 in order to coincide with implementation of the RBRVS. A one-year delay would be administratively simple, fair to all specialties and geographic areas, and would prevent unintended reductions for those services or physicians expecting increases under the RBRVS.

The argument that a delay of physician-wide balance billing limits in 1991 might somehow help the "wrong" physicians is inaccurate. Delay of implementation of this requirement would protect physicians providing underpaid services -- family physicians, internists, certain anesthesiologists in low-pay states etc. -- but would not interfere with the application of current law balance billing limits for those services subject to reductions in 1991.

According to current law, whenever a procedure/service is reduced under the inherent reasonableness or overvalued process, a special MAAC is automatically applied requiring a first year limit of 1/2 the difference between the previous year's MAAC and 125 percent of the Medicare approved (prevailing) charge, and a second year limit of 125 percent. This legislated formula has been used since 1986 (cataract surgery and associated anesthesia services), and was applied to the procedures reduced as part of the past two budget bills.

Achieving relief from the unintended effects of the 1991 balance billing limits by delaying implementation, yet applying existing special MAAC law to those services which are reduced, is a cleaner, simpler method than achieving relief by trying to pick out particular services or localities for exemption. Beneficiaries will still receive "savings" as any reduced procedure would carry the special MAAC.

Conclusion

The American Society of Anesthesiologists is ready to work with the Subcommittee and full Committee as this most difficult budget cycle proceeds. We believe the proposals we have outlined would provide significant savings -- $65 million for FY 91 -- in a manner that should not disrupt or jeopardize the delivery of care. Our Society will be pleased to provide any additional information and we look forward to continuing what has always been a constructive relationship with the Subcommittee.

Mr. WAXMAN. Thank you very much, Dr. Stephenson.
Mr. Rogers.

STATEMENT OF LEE F. ROGERS

Mr. ROGERS. Thank you, Mr. Chairman.

I am Lee Rogers, radiologists from Chicago and please let the record read that I live in Congresswoman Collins' district, and I work there, also, at the principal hospital, Northwestern Memorial Hospital. I am here as chairman of the board of chancellors of the American College of Radiologists.

As a result of legislation initiated by the subcommittee, the college has worked with the Health Care Financing Administration for the past 3 years developing and implementing a fee schedule for radiology services to Medicare recipients. We have provided periodic updates of those activities to the subcommittee staff and the Physicians Payment Review Commission.

We are pleased with the responsiveness of HCFA in implementing the legislation and we have gained insight into problems inherent in the implementation of a fee schedule which should be of value in preparation for the initiation of the general Medicare fee schedule planned for 1992.

These have been chaired with this committee, HCFA and the PPRC on previous occasions. We recognize the tremendous dilemma faced in resolving the budget deficit. In the process of resolving this crisis, however, it should not be necessary to dramatically alter the ground rules for the long sought, long awaited and in some quarters greatly desired physician payment reform.

We maintain that Medicare budget savings can be achieved while payment reform proceeds with fairness to all, as previously planned. We urge the required cuts in Medicare be spread equally over the entire spectrum of health care services, including radiology, and that such cuts be made independent of changes to accomplish physician payment reform.

Individual specialties, or Medicare localities, should not be singled out and targeted in a manner that departs from and violates all previously agreed-upon equitable arrangements for comprehensive reform.

The hard work of the Congress and the PPRC on long-awaited payment reform should not be scuttled to resolve current budget problems. One of the major points made by Congress in OBRA 1989 is needed to phase in changes over time, and we heartily endorse this concept.

With this in mind, we urge rejection of the President's proposal to cut radiology payments 10 percent. If that recommendation is accepted, radiology will then have been subjected to a greater reduction than called for under physician payment reform. We ask you to consider the changes in radiology reimbursement.

Over the last 3 years, since implementation of the radiology fee schedule, there have been significant reductions already totalling 12 to 14 percent. Because of these reductions, radiology is no longer overvalued to the extent envisioned by the Harvard standard study and PPRC projections.

We recommend you begin to adjust the now existing but rather inexplicable wide variation in radiology conversion factors among the 240 Medicare localities. Furthermore, we believe geographic adjustment should be made in a mutual fashion.

PPRC has recommended geographic variation adjustments be used to obtain the 4 percent savings in radiology. Their proposal would simply reduce the highest conversion factors. We do not support this proposal.

The fact the payments mean localities need to be adjusted to reflect legitimate differences in costs should not be seized upon as a means to address the budget deficit. If it is true, based on cost of practice, the conversion factors believed to be high should be reduced, it must be equable, true, unquestionably low conversion factors should be adjusted upwards.

This context to adjust only those recognized as high, seems intrinsically unfair. The American College of Radiology urges the subcommittee to recognize the radiologists have already experienced a majority of the 21 percent cut recommended by the PPRC in 1988.

We further urge you to adopt a rational plan for correcting the surprisingly marked geographic variations which now exist in radiology conversation factors. In fact, we recommend you begin as soon as possible, preferably in 1991, with phase-in adjustments ending in 1996.

We also urge that the remainder of the reductions for radiology necessitated by the resource base physician payment scheme be rephased in over the period. Thank you very much.

[Testimony resumes on p. 173.]

[The prepared statement and attachments of Mr. Rogers follow:]

Testimony of the American College of Radiology

by

Lee F. Rogers, M.D.

The American College of Radiology is pleased to present the following comments and information for the record of the hearing of the Subcommittee on Health regarding Medicare issues in the 1991 budget reconcilation bill.

The ACR, as a result of legislation initiated by the subcommittee, has worked for the past three years in developing and implementing a fee schedule for Medicare payments for radiology services. We have worked closely with the Health Care Financing Administration in all aspects of the fee schedule. We have provided updates of those activities to the subcommittee staff and the Physician Payment Review Commission.

We have gained valuable insight into implementing a fee schedule and identified many problems which will be applicable to implementation of the general Medicare fee schedule to be implemented in 1992. We are pleased that the subcommittee provided the legislative authority for development of the radiology fee schedule. We are equally pleased with the responsiveness of the Health Care Financing Administration in implementing the legislation.

The ACR is concerned about changes to the Medicare law that will affect the radiology fee schedule. We recognized in 1987 that major changes in the way physicians are paid for their services to Medicare patients were in the making and were willing participants in developing the details. We also recognized that inherent in physician payment reform was the possibility of cuts in payment levels for radiology services.

We recognize the tremendous dilemma you face in resolving the budget deficit crisis. We hope in the process of resolving that crisis, it is not necessary to dramatically alter the ground rules for physician payment reform. We urge that Medicare budget savings be attained in a way that still allows payment reform to proceed in a fair manner so that individual categories of physician services are not targeted for savings in a manner that eliminates a rational period in which to spread the effects of change.

We are concerned that the recommendations currently before the subcommittee would jeopardize the intent of a fair and reasonable method for physician payment reform. We believe that the

recommendations of the President regarding Medicare spending cuts for FY 1991 are inappropriate and should be rejected. Additionally, the ACR disagrees with the recommendations by the Physician Payment Review Commission regarding 1991 changes to radiology payments under the Medicare program.

The PPRC has recommended that geographic variation adjustments should be used to obtain their recommended four percent savings from radiology. Their proposal would reduce the highest conversion factors and not adjust the lowest conversion factors. We do not support this proposal. We believe that geographic adjustments between Medicare localities and between states should be made in a budget neutral way.

The fact that payments among localities need to be adjusted to reflect legitimate differences in costs is not a budget deficit issue. It is a cost of practice issue. If it is true that conversion factors that are too high based on cost of practice should be reduced, it is just as true that conversion factors that are too low should be adjusted upward. An adjustment only to those with conversion factors that are high punishes both the high localities and the low localities. Even though there is still a projection that radiology is overvalued after experiencing the cuts to date, there are many Medicare localities where radiology services are undervalued based on the index of cost of practice.

Additionally, it is unfair to make a single adjustment in payments in a locality in one year which may equal the total adjustment anticipated to correct for geographic variation in that locality. One of the major points made by the Congress in OBRA of 1989 is the need to phase in changes over time.

Alternatively, we urge the subcommittee to adopt a systematic plan for further adjustments to the radiology fee schedule, which would include a rationalization of the geographic variations in conversion factors for the radiology fee schedule and a recognition that further cuts in radiology payments under Medicare be phased-in over a period of time similar to that which was adopted in OBRA of 1989 for the general Medicare fee schedule.

The ACR proposes that the adjustments for geographic variation begin in 1991 and that six equal adjustments be made to conversion factors with the final adjustment being made on January 1, 1996. The adjustments would be made using the cost of practice index and physician work component index developed by the Urban Institute for the Health Care Financing Administration. We will provide the subcommittee with a detailed description of the process for adjusting conversion factors for the radiology fee schedule, as well as, a discussion and explanation of the use of the geographic

cost of practice index in rationalizing radiology conversion factors. Further we will provide examples of the effect of geographic adjustments on the current conversion factors.

An additional factor for consideration in your budget discusssions is the issue of adjustments to specialty payments under the RBRVS concept. The American College of Radiology urges the subcommittee to recognize that radiologists have experienced most of the 21 percent cut recommended by the PPRC in 1988. We urge you to consider the changes in radiology reimbursement levels which have occurred over the last three years. Since implementation of the radiology fee schedule, there have been significant reductions in payments for radiologists totaling 12 to 14 percent. Because of these reductions, radiology is no longer overvalued to the extent envisioned by the Harvard study and the PPRC projections in 1988.

With this in mind we urge rejection of the President's proposal to cut radiology payments ten percent. If that recommendation is accepted, radiology will have taken more cuts than called for under physician payment reform.

The ACR has spent a great deal of time analyzing the common problems with implementation of a fee schedule: From development of the comprehensive study of radiology resources and costs, which was initiated by this subcommittee three years ago, to detailed analysis of calculation of conversion factors by Medicare carriers. Building on this experience, we urge the subcommittee to adopt a plan for rationally adjusting for geographic variation in radiology conversion factors beginning in 1991 with phased-in adjustments ending in 1996. We also urge that the remainder of the adjustment necessary for radiology under the resource based physician payment scheme be phased-in over the same time period.

Sincerely,

Lee F. Rogers

Lee F. Rogers, M.D.
Chairman, ACR Board of Chancellors

LFR/pgm

acr

Attachment # 1

American College of Radiology Proposal for Transition to the Rationalized Geographic Variation in Reimbursement Called for by OBRA 1989

Current Medicare conversion factors for radiology vary in a crazy-quilt fashion with no rational basis, reflecting only the past history of payment levels. For example, the highest conversion factor, $18.10, is found in southern Illinois, clearly not the most expensive place in the U.S. The geographic areas used have little logical basis or uniformity and range from entire states to sections of a city and even a small number of providers selected on a non-geographic basis.

In September 1989, the American College of Radiology called for a rationalization of geographic variation, with differences in payment levels to be based on rational grounds such as differences in cost of practice and cost of living. In November 1989, Congress enacted OBRA 89 which provides for physician payment by fee schedule for all of Medicare, and provides a formula for geographic differences in payment levels: Differences in payment levels will fully incorporate differences in costs of practice, but will incorporate only one-fourth of cost-of-living differences.[1]

This proposal contains the ACR's suggestions for moving to a pattern of geographic differences that follows the OBRA rule.

[1]Strictly speaking, simulations have used not cost of living, but an estimate of opportunity costs that consists of an index of earnings of non-physician professionals with extensive education. This proposal uses the term "cost of living" because that term is more familiar; it does not intend any recommendation regarding the best index to use.

1. Basic Plan

Basically, the ACR proposal is to adjust conversion factors each year in all areas by one-sixth of the amount they differ from their correct level relative to the national average. The first adjustment would take place on January 1, 1991 and the sixth and last adjustment would take place on January 1, 1996. Thus radiology would begin the transition to rationalized geographic variation one year ahead of the rest of medicine, and would thereby serve as a "shakedown" vehicle for recognizing and solving the implementation problems that arise in rationalization. Radiology would complete the transition to rationalized geographic variation at the same time as the rest of medicine.

2. Details

a. Adjusting Relative Payment Levels

Each area's conversion factor currently is some multiple or fraction of the nationwide average conversion factor. Call this relationship the "current relative conversion factor," or CRCF, and define it numerically as the area's conversion factor divided by the national average. For example, after the April 1, 1990 reduction, the national average conversion factor is $12.82 and the southern Illinois conversion factor is $18.10, so this area's CRCF is $18.10/$12.82, or 1.412. In other words, its conversion factor is 1.412 times the national average. Using this terminology, the conversion factor in each area currently equals (CRCF) x (1990 national average radiology conversion factor).

Each area has a proper ultimate relationship between its conversion factor and the national average, again defining the relationship as a multiple or fraction of the national average conversion factor. This relationship is often called the "geographic practice cost index" GPCI, and the relevant equation is:

proper conversion factor = GPCI x (national average conversion factor)

The GPCI is a suitably weighted index of (1) indexes of practice cost components such as employee compensation and office rent and (2) an adjusted cost-of-living index that reflects one-fourth the difference between an area's cost-of-living and the national average cost-of-living.

The ACR proposal would have the conversion factor in an area in 1991 be (1/6 GPCI plus 5/6 CRCF) x (1991 national average radiology conversion factor). In 1992, an area's conversion factor would be (1/3 GPCI plus 2/3 CRCF) x (1992 national average radiology conversion factor). The adjustment process would continue until, with the sixth step, an area's conversion 1996 factor was simply (GPCI) x (1996 national average conversion factor).

b. GPCIs for Radiology

The PPRC has, we understand, recommended an approach to practice costs which would categorize services into groups characterized by similarity in the mix of resources used in rendering the services. (Resources include physician's own work, employees, office costs, professional liability insurance, etc.) Under the PPRC approach, the treatment of practice costs would be the same for all services in a group.

In terms of resources used, radiologists provide two quite different types of services:

1. Professional component services, which consist largely of physicians' own work. Another organization (most often a hospital) pays for technicians, equipment, space, etc., and charges for these resources.
2. Global services, in which the radiologist provides not only his own work, but also technicians, equipment, etc.

In keeping with the PPRC-recommended approach, the ACR sugggests that professional component services and global services each be regarded as a group.

The ACR therefore recommends that a GPCI for professional component services and a separate GPCI for global services be calculated, and that these GPCIs be used in the adjustment of relative payment levels that is described in (a), above.

The ACR is preparing estimates of the shares of various resources (physicians' work, employee compensation, office, etc.) that would go into these GPCIs. These estimates will be based on:

- o Analysis of data from a very small number of practices that tabulate hospital-based and office-based costs separately.
- o A preliminary consensus panel process to be completed in mid-May.
- o Linkage to known totals for overall radiology practices (global and professional services combined) from the AMA's Socio-Economic Survey and HCFA's Physician Practice Cost and Income Survey (PPCIS).

These estimates will be available in mid to late May, and will be fowarded to the PPRC and HCFA at that time.

The ACR recommends that as improved estimates of the resource cost shares entering into professional and global services are developed and validated, these improved estimates be used in calculating GPCIs. For example, the PPRC has underway a large-scale effort to gather practice cost data, based extensively on data from large, multi-specialty group practices. When that effort has produced its results, and these results are validated as typical of medical practices as a whole, not merely large-scale group practices, then these results should be used in the GPCIs for professional and global services.

Full details of the practicalities of how the PPRC would include practice costs in the calculation of payments have not yet been announced. To the extent the formulas used are similar in substance but different in form from the use of GPCIs as described above, they would seem appropriate. For example, payments for each service might be the sum of three components—one for physicians' work, one for professional liability insurance, and one for all other practice expenses. With this formula in use, there would be three GPCIs, one for each component, used with each service. The GPCI for physicians' work would be the same for all services delivered in an area while the other GPCIs probably would be more individualized to the particular type of service involved.

c. Geographic Areas

As noted, the geographic areas now used in the radiology fee schedule (areas which often, but far from always, are carrier charge localities) have little rhyme or reason and vary in size from individual states to portions of a city or even a few selected practices.

The ACR supports the intention of involved federal government organizations to rationalize geographic payment areas. It defers to the expertise of these organizations as regards the specific geographic rationalization that is judged best.

Attachment #2

The GPCI for the Radiology Fee Schedule

Overview

The GPCI for the radiology fee schedule follows both the general principles of geographic payment variation planned by the Federal Government for Medicare and the details of this variation that the Government has decided upon.

Specifically, under the generally Medicare fee schedule and the special Medicare fee schedules for radiology and anesthesiology, Medicare's allowed charge for a service in each geographic area will be

allowed charge = (RVUs) x (national average conversion factor) x (area GPCI)[1].

In this formula, "RVUs" is the number of relative value units the relative value scale assigns to the service and the "area GPCI" (geographic practice cost index) is a measure of how practice expenses and cost-of-living in an area compare with the national average. (The national average GPCI is given the value 1.00.) The radiology GPCI fits this formula.

The calculated radiology GPCI follows the specific details of GPCIs that have been decided by the Federal Government. In particular,

- As stipulated by OBRA 1989, the radiology GPCI reflects the full difference among areas in practice expenses, but only one-fourth the difference among areas in cost-of-living.

- The index for each area for each component of the GPCI is taken from technical studies of GPCIs carried out for HCFA. (The data were compiled under contract to HCFA by the Urban Institute and appear in the Institute's June 1989 study of GPCIs entitled "The Geographic Medicare Economic Index: Alternative Appproaches.") The five components of the radiology GPCI are those in this data base: office costs, employee compensation, malpractice, physician's own time, and all other.

- The Physician Payment Review Commission has recommended that the weights of the components in the GPCI reflect the shares of each component in the costs of a service, with services grouped into categories and each category having a separate set of weights. The GPCI for radiology uses cost weights for radiologic services. Thus, in terms of the conceptual scheme described at the beginning of this bullet, radiologic services are treated as one category of services.

[1] In actuality, a more complex formula is stipulated which, in effect, has 3 payment components and 3 GPCIs in each area, one each for physician's own time, malpractice costs, and other practice expenses. For more information, see below under "details".

Details

1. The payment formula. OBRA specifies that the payment for each service will have three components: one each for (1) physician's own work, (2) malpractice costs, and (3) other practice expenses. To implement this provision for all services requires at least three GPCIs for each area—one each for malpractice, other practice expenses, and physician's own work. However, for services that fall into a single category (in the sense that they have the same share of malpractice costs, other practice expenses and physician's work in their costs), the OBRA specification is mathematically equivalent to a single GPCI. This category-specific GPCI weights its components according to their share in the costs of services in the category. Services in a different category will have a different category-specific GPCI, because the weights of the cost factors in the appropriate GPCI will be different.

2. The Radiology GPCI. The radiology GPCI that was computed weights each cost factor according to that factor's cost weight for radiology in the latest AMA socioeconomic survey. (The Urban Institute's study for HCFA recommends this AMA survey as the best source of up-to-date data.) Based on data in the AMA's Socioeconomic Characteristics of Medical Practice, 1989, cost shares for radiology are:

physician's own work	60%
employee compensation	13%
office costs	9%
malpractice costs	3%
all other	15%

These are the shares used in the computed radiology GPCI.

3. One Radiology GPCI or Two? It might be thought that there should be two GPCIs for radiology, one for professional component services and another for global services, because cost shares for these two types of services are quite different. In particular, professional component services are usually provided in an institution, with the institution supplying space, equipment, and technicians. Thus physicians' work is the predominant cost share in professional component services. In global services, in contrast, the radiologist supplies and faces costs for facilities, equipment, and technicians. Physician's own work has a cost share of only about one-third in global services.

Preliminary analyses computed separate GPCIs for professional component and global services. Each of these separate GPCIs differed from the all-radiology single GPCI by an average of less than 1/2 percent. Morever, in areas where more than 90 percent of radiology is performed, the difference was less than 1 percent. Therefore, the simplicity of a single GPCI for all radiologic services seems preferable to the largely theoretical improvement to be gained from two GPCIs.

4. Renormalization. For the formulas to work correctly, the weighted national average GPCI must equal 1.00. The Urban Institute's study for HCFA achieved this goal by weighting each area by its population and then making the necessary adjustments to bring the average, thus weighted, to 1.00.

In computing the radiology GPCI, weights more appropriate to Medicare and radiology were used. Specifically, for GPCIs computed for carrier localities, the weight in each locality was the number of radiology RVUs in the locality that the Medicare carrier identified when the radiology fee schedule was orginally implemented in the Spring of 1989. For GPCIs for metropolitan statistical areas (MSAs) and state-wide non-metro areas, weights were the measure of Medicare volume of services developed by PPRC staff.

Radiology GPCIs computed with the HCFA/Urban Institute data were "renormalized" using these weights. That is, the weighted national average was computed using these weights and the initially-computed GPCIs in all areas were then divided by the national average. The renormalization produced a change of less than 1 percent.

Prior to renormalization, an index for physicians' work that reflects one-fourth of cost-of-living differences was substituted for the original Urban Institute index that reflects the full difference. The new index was computed as .25 x (old index) + .75.

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
ABILENE, TX	12.96	11.86	-8.5	0.925
AKRON, OH	12.18	12.67	4.0	0.988
ALBANY, GA	12.32	12.19	-1.0	0.951
ALBANY-SCHENECTADY-T	13.07	12.73	-2.5	0.993
ALBUQUERQUE, NM	13.38	12.45	-7.0	0.970
ALEXANDRIA, LA	12.18	12.29	0.9	0.959
ALLENTOWN-BETHLEHEM,	13.16	12.67	-3.8	0.987
ALTOONA, PA	12.24	12.25	0.0	0.955
AMARILLO, TX	12.96	12.06	-7.0	0.940
ANAHEIM-SANTA ANA, C	15.72	13.78	-12.3	1.075
ANDERSON, IN	11.84	12.27	3.7	0.956
ANDERSON, SC	10.44	11.93	14.2	0.930
ANKORAGE AK	16.32	14.60	-10.5	1.138
ANN ARBOR, MI	12.59	13.05	3.7	1.018
ANNISTON, AL	11.54	12.20	5.7	0.951
APPLETON-OSHKOSH-NEE	12.18	12.38	1.6	0.965
ASHEVILLE, NC	11.82	11.88	0.6	0.926
ATHENS, GA	12.32	11.98	-2.7	0.934
ATLANTA, GA	12.33	12.52	1.6	0.976
ATLANTIC CITY, NJ	15.12	12.98	-14.2	1.012
AUGUSTA, GA-SC	10.44	12.11	16.0	0.944
AURORA-ELGIN, IL	12.56	12.89	2.6	1.005
AUSTIN, TX	14.39	12.16	-15.5	0.948
BAKERSFIELD, CA	13.10	13.33	1.8	1.039
BALTIMORE, MD	14.04	13.14	-6.4	1.024

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
BANGOR, ME	10.85	11.97	10.3	0.933
BATON ROUGE, LA	12.15	12.53	3.1	0.977
BATTLE CREEK, MI	11.15	13.13	17.8	1.024
BEAUMONT-PORT ARTHUR	13.76	12.39	-9.9	0.966
BEAVER COUNTY, PA	13.16	12.72	-3.4	0.992
BELLINGHAM, WA	10.82	12.84	18.6	1.001
BENTON HARBOR, MI	11.15	12.63	13.3	0.985
BERGEN-PASSAIC, NJ	13.76	13.43	-2.4	1.047
BILLINGS, MT	12.38	12.38	0.0	0.965
BILOXI-GULFPORT, MS	10.21	12.23	19.7	0.953
BINGHAMTON, NY	13.07	12.48	-4.5	0.973
BIRMINGHAM, AL	11.25	12.38	10.0	0.965
BISMARCK, ND	10.92	12.31	12.8	0.960
BLOOMINGTON, IN	11.06	11.94	8.0	0.931
BLOOMINGTON-NORMAL,	11.46	12.77	11.4	0.996
BOISE CITY, ID	9.93	12.51	26.0	0.975
BOSTON, MA	12.35	13.05	5.7	1.017
BOULDER-LONGMONT, CO	10.17	12.45	22.5	0.971
BRADENTON, FL	13.15	12.33	-6.2	0.961
BRAZORIA, TX	13.76	12.58	-8.6	0.980
BREMERTON, WA	10.82	13.13	21.3	1.023
BRIDGEPORT-MILFORD,	14.07	13.62	-3.2	1.062
BROWNSVILLE-HARLINGE	13.76	12.03	-12.6	0.938
BRYAN-COLLEGE STATIO	13.76	12.05	-12.4	0.939
BUFFALO, NY	10.36	12.72	22.8	0.992
BURLINGTON, NC	11.82	12.00	1.6	0.936

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
BURLINGTON, VT	11.59	12.12	4.6	0.945
CANTON, OH	12.18	12.51	2.7	0.975
CASPER, WY	11.03	12.75	15.6	0.994
CEDAR RAPIDS, IA	9.34	12.38	32.5	0.965
CHAMPAIGN-URBANA-RAN	13.71	12.39	-9.6	0.966
CHARLESTON, SC	10.44	12.07	15.5	0.941
CHARLESTON, WV	13.96	12.57	-10.0	0.980
CHARLOTTE-GASTONIA-R	10.44	12.09	15.7	0.942
CHARLOTTESVILLE, VA	12.01	12.09	0.7	0.943
CHATTANOOGA, TN-GA	12.88	12.09	-6.1	0.943
CHEYENNE, WY	11.03	12.53	13.6	0.977
CHICAGO, IL	14.44	13.90	-3.7	1.084
CHICO, CA	12.70	12.86	1.3	1.003
CINCINNATI, OH-KY-IN	13.32	12.68	-4.8	0.989
CLARKSVILLE-HOPKINSV	12.88	11.86	-7.9	0.925
CLEVELAND, OH	14.27	12.97	-9.0	1.012
COLORADO SPRINGS, CO	10.17	12.27	20.7	0.957
COLUMBIA, MO	12.27	12.23	-0.3	0.954
COLUMBIA, SC	10.44	12.06	15.5	0.940
COLUMBUS, GA-AL	13.41	11.96	-10.8	0.932
COLUMBUS, OH	13.28	12.56	-5.4	0.980
CORPUS CHRISTI, TX	13.76	12.16	-11.6	0.948
CUMBERLAND, MD-WV	12.97	12.31	-5.1	0.960
DALLAS, TX	13.89	12.50	-10.0	0.975
DANVILLE, VA	10.88	12.01	10.4	0.936
DAVENPORT-ROCK ISLAN	10.49	12.66	20.7	0.987

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
DAYTON-SPRINGFIELD,	13.04	12.70	-2.5	0.990
DAYTONA BEACH, FL	13.15	12.37	-6.0	0.964
DECATUR, IL	13.66	12.76	-6.6	0.994
DENVER, CO	10.17	12.89	26.8	1.005
DES MOINES, IA	9.48	12.49	31.7	0.974
DETROIT, MI	12.59	14.08	11.9	1.098
DOTHAN, AL	11.72	12.11	3.3	0.944
DUBUQUE, IA	9.34	12.21	30.7	0.952
DULUTH, MN-WI	10.40	12.54	20.6	0.977
EAU CLAIRE, WI	11.15	12.22	9.6	0.953
EL PASO, TX	12.96	12.17	-6.1	0.948
ELKHART-GOSHEN, IN	11.06	12.27	10.9	0.956
ELMIRA, NY	12.96	12.48	-3.7	0.973
ENID, OK	9.53	11.98	25.7	0.934
ERIE, PA	13.16	12.49	-5.1	0.974
EUGENE-SPRINGFIELD,	9.56	12.56	31.3	0.979
EVANSVILLE, IN-KY	11.64	12.24	5.2	0.954
FALL RIVER, MA-RI	11.09	12.54	13.1	0.978
FARGO-MOORHEAD, ND-M	10.92	12.24	12.1	0.954
FAYETTEVILLE, NC	11.82	12.06	2.0	0.940
FAYETTEVILLE-SPRINGD	11.62	11.53	-0.7	0.899
FLINT, MI	11.15	13.74	23.3	1.071
FLORENCE, AL	11.05	12.34	11.7	0.962
FLORENCE, SC	10.44	11.98	14.7	0.934
FORT COLLINS-LOVELAN	10.17	12.27	20.7	0.956
FORT LAUDERDALE-HOLL	14.46	13.03	-9.8	1.016

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
FORT MYERS-CAPE CORA	14.46	12.48	-13.7	0.973
FORT PIERCE, FL	13.15	12.53	-4.7	0.977
FORT SMITH, AR-OK	11.62	11.86	2.1	0.924
FORT WALTON BEACH, F	12.33	12.26	-0.5	0.956
FORT WAYNE, IN	11.84	12.39	4.6	0.966
FORT WORTH-ARLINGTON	13.73	12.16	-11.4	0.948
FRESNO, CA	12.60	13.10	3.9	1.021
GADSDEN, AL	11.54	12.21	5.8	0.952
GAINESVILLE, FL	13.15	12.28	-6.6	0.957
GALVESTON-TEXAS CITY	13.76	12.43	-9.6	0.969
GARY-HAMMOND, IN	11.84	12.92	9.1	1.007
GLENS FALLS, NY	13.07	12.44	-4.8	0.970
GRAND FORKS, ND	10.92	12.16	11.4	0.948
GRAND RAPIDS, MI	11.15	12.83	15.1	1.001
GREAT FALLS, MT	12.38	12.33	-0.4	0.961
GREELEY, CO	10.17	12.16	19.6	0.948
GREEN BAY, WI	12.18	12.43	2.0	0.969
GREENSBORO-WINSTON-S	11.82	12.05	1.9	0.939
GREENVILLE-SPARTANBU	10.44	11.99	14.8	0.935
HAGERSTOWN, MD	12.97	12.50	-3.6	0.974
HAMILTON-MIDDLETOWN,	13.33	12.64	-5.2	0.985
HARRISBURG-LEBANON-C	12.69	12.70	0.0	0.990
HARTFORD, CT	14.10	13.00	-7.8	1.013
HICKORY, NC	11.82	11.71	-0.9	0.913
HONOLULU, HI	13.67	13.07	-4.4	1.019
HOUMA-THIBODAUX, LA	11.59	12.39	6.9	0.966

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
HOUSTON, TX	14.61	12.84	-12.1	1.001
HUNTINGTON-ASHLAND,	13.96	12.29	-12.0	0.958
HUNTSVILLE, AL	11.05	12.33	11.6	0.961
INDIANAPOLIS, IN	11.84	12.46	5.3	0.971
IOWA CITY, IA	13.23	12.20	-7.8	0.951
JACKSON, MI	11.15	13.09	17.5	1.021
JACKSON, MS	10.21	12.17	19.2	0.949
JACKSON, TN	12.88	11.98	-7.0	0.934
JACKSONVILLE, FL	13.15	12.53	-4.8	0.976
JACKSONVILLE, NC	11.82	11.90	0.7	0.927
JANESVILLE-BELOIT, W	10.52	12.29	16.8	0.958
JERSEY CITY, NJ	13.76	13.43	-2.4	1.047
JOHNSON CITY-KINGSPR	12.88	12.04	-6.5	0.939
JOHNSTOWN, PA	12.69	12.46	-1.8	0.971
JOLIET, IL	12.56	13.09	4.3	1.021
JOPLIN, MO	10.23	12.27	19.9	0.957
KALAMAZOO, MI	11.15	13.03	16.9	1.016
KANKAKEE, IL	14.11	12.56	-11.0	0.979
KANSAS CITY, MO-KS	11.65	12.68	8.8	0.989
KENOSHA, WI	10.84	12.71	17.3	0.991
KILLEEN-TEMPLE, TX	13.31	11.97	-10.1	0.933
KNOXVILLE, TN	12.88	11.96	-7.1	0.933
KOKOMO, IN	11.06	12.48	12.9	0.973
LA CROSSE, WI	11.15	12.06	8.2	0.940
LAFAYETTE, IN	11.06	11.93	7.9	0.930
LAFAYETTE, LA	12.53	12.45	-0.7	0.970

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
LAKE CHARLES, LA	13.09	12.33	-5.8	0.961
LAKE COUNTY, IL	12.56	13.25	5.5	1.033
LAKELAND-WINTER HAVE	13.15	12.30	-6.5	0.959
LANCASTER, PA	12.24	12.46	1.8	0.971
LANSING-EAST LANSING	11.15	13.02	16.8	1.015
LAREDO, TX	13.76	11.84	-13.9	0.923
LAS CRUCES, NM	13.38	12.04	-10.0	0.939
LAS VEGAS, NV	15.26	13.31	-12.8	1.037
LAWRENCE, KS	12.43	11.94	-4.0	0.931
LAWTON, OK	10.68	12.04	12.8	0.939
LEWISTON-AUBURN, ME	10.85	11.81	8.9	0.921
LEXINGTON-FAYETTE, K	11.64	12.18	4.7	0.950
LIMA, OH	13.19	12.39	-6.1	0.966
LINCOLN, NE	14.28	11.94	-16.4	0.931
LITTLE ROCK-NORTH LI	11.62	12.08	4.0	0.942
LONGVIEW-MARSHALL, T	13.31	12.06	-9.3	0.940
LORAIN-ELYRIA, OH	14.27	12.59	-11.7	0.982
LOS ANGELES-LONG BEA	16.38	13.94	-14.9	1.087
LOUISVILLE, KY-IN	11.64	12.36	6.2	0.963
LUBBOCK, TX	12.96	11.83	-8.7	0.922
LYNCHBURG, VA	10.88	11.93	9.7	0.930
MACON-WARNER ROBINS,	13.41	12.13	-9.6	0.945
MADISON, WI	10.05	12.40	23.4	0.967
MANCHESTER, NH	11.78	12.30	4.4	0.959
MANSFIELD, OH	12.15	12.40	2.0	0.966
MCALLEN-EDINBURG-MIS	13.76	11.71	-14.9	0.913

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
MEDFORD, OR	10.69	12.52	17.1	0.976
MELBOURNE-TITUSVILLE	13.15	12.51	-4.9	0.975
MEMPHIS, TN-AR-MS	12.88	12.13	-5.8	0.946
MERCED, CA	12.40	13.10	5.6	1.021
MIAMI-HIALEAH, FL	15.79	13.47	-14.7	1.050
MIDDLESEX-SOMERSET-H	13.76	13.51	-1.8	1.053
MIDLAND, TX	12.96	12.65	-2.4	0.986
MILWAUKEE, WI	12.49	12.78	2.4	0.997
MINNEAPOLIS-ST. PAUL	10.43	12.89	23.6	1.005
MOBILE, AL	11.44	12.18	6.4	0.949
MODESTO, CA	12.40	13.14	5.9	1.024
MONMOUTH-OCEAN, NJ	13.61	13.19	-3.1	1.029
MONROE, LA	14.03	12.21	-13.0	0.952
MONTGOMERY, AL	11.72	12.33	5.2	0.961
MUNCIE, IN	11.84	12.12	2.4	0.945
MUSKEGON, MI	11.15	12.83	15.1	1.000
NAPLES, FL	14.46	12.71	-12.1	0.991
NASHVILLE, TN	12.88	12.14	-5.8	0.946
NASSAU-SUFFOLK, NY	14.04	14.17	0.9	1.104
NEW HAVEN-MERIDEN, C	14.07	12.90	-8.3	1.006
NEW LONDON-NORWICH,	11.09	12.89	16.3	1.005
NEW ORLEANS, LA	13.62	12.88	-5.5	1.004
NEW YORK, NY	14.51	14.38	-0.9	1.121
NEWARK, NJ	13.76	13.51	-1.8	1.053
NIAGARA FALLS, NY	10.36	12.76	23.2	0.995
NORFOLK-VA BEACH-NEW	12.43	12.29	-1.2	0.958

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
Non-metro - AK	16.32	14.54	-10.9	1.134
Non-metro - AL	11.21	12.08	7.8	0.942
Non-metro - AR	11.62	11.61	0.0	0.905
Non-metro - AZ	12.93	12.55	-2.9	0.979
Non-metro - CA	12.84	12.89	0.4	1.005
Non-metro - CO	10.17	12.13	19.3	0.945
Non-metro - CT	14.19	12.66	-10.8	0.987
Non-metro - DE	13.14	12.28	-6.5	0.957
Non-metro - FL	14.04	12.15	-13.4	0.947
Non-metro - GA	12.64	11.87	-6.1	0.925
Non-metro - HI	13.67	12.87	-5.8	1.004
Non-metro - IA	9.93	12.01	21.0	0.937
Non-metro - ID	10.07	12.22	21.4	0.953
Non-metro - IL	14.06	12.42	-11.7	0.968
Non-metro - IN	10.76	12.05	12.0	0.939
Non-metro - KS	12.43	11.87	-4.5	0.925
Non-metro - KY	10.43	12.03	15.4	0.938
Non-metro - LA	11.59	12.10	4.4	0.943
Non-metro - MA	13.33	12.53	-6.1	0.977
Non-metro - MD	13.63	12.42	-8.9	0.968
Non-metro - ME	10.85	11.93	10.0	0.930
Non-metro - MI	12.00	12.63	5.2	0.984
Non-metro - MN	10.05	12.15	20.8	0.947
Non-metro - MO	11.21	12.05	7.5	0.939
Non-metro - MS	11.13	11.83	6.3	0.922
Non-metro - MT	12.38	12.15	-1.9	0.947

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
Non-metro - NC	11.82	11.74	-0.6	0.915
Non-metro - ND	10.92	11.99	9.8	0.934
Non-metro - NE	12.22	11.69	-4.4	0.911
Non-metro - NH	11.78	12.01	2.0	0.936
Non-metro - NM	13.38	12.19	-8.9	0.951
Non-metro - NV	14.04	12.84	-8.6	1.001
Non-metro - NY	13.06	12.35	-5.4	0.963
Non-metro - OH	12.78	12.32	-3.6	0.961
Non-metro - OK	10.10	11.88	17.6	0.926
Non-metro - OR	10.66	12.49	17.2	0.973
Non-metro - PA	12.24	12.36	0.9	0.963
Non-metro - RI	11.09	12.50	12.8	0.975
Non-metro - SC	10.44	11.81	13.1	0.921
Non-metro - SD	9.85	11.75	19.3	0.916
Non-metro - TN	12.88	11.76	-8.7	0.917
Non-metro - TX	13.33	11.78	-11.6	0.919
Non-metro - UT	10.63	12.36	16.3	0.963
Non-metro - VA	11.55	11.92	3.2	0.929
Non-metro - VT	11.59	11.80	1.8	0.920
Non-metro - WA	11.50	12.65	10.0	0.986
Non-metro - WI	11.38	12.05	5.9	0.939
Non-metro - WV	13.05	12.03	-7.8	0.938
Non-metro - WY	11.03	12.25	11.1	0.955
OAKLAND, CA	12.60	13.92	10.5	1.085
OCALA, FL	12.33	12.11	-1.8	0.944
ODESSA, TX	12.96	12.41	-4.2	0.968

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
OKLAHOMA CITY, OK	10.01	12.22	22.1	0.953
OLYMPIA, WA	10.82	13.10	21.1	1.022
OMAHA, NE-IA	14.28	12.16	-14.8	0.948
ORANGE COUNTY, NY	12.96	13.07	0.9	1.019
ORLANDO, FL	13.15	12.52	-4.8	0.976
OWENSBORO, KY	10.70	12.24	14.3	0.954
OXNARD-VENTURA, CA	15.60	13.49	-13.5	1.052
PANAMA CITY, FL	12.33	12.23	-0.8	0.954
PARKERSBURG-MARIETTA	12.88	12.17	-5.6	0.948
PASCAGOULA, MS	11.12	12.15	9.3	0.948
PENSACOLA, FL	13.15	12.33	-6.3	0.961
PEORIA, IL	12.16	13.16	8.2	1.026
PHILADELPHIA, PA-NJ	13.08	13.46	2.9	1.050
PHOENIX, AZ	11.13	12.88	15.8	1.004
PINE BLUFF, AR	11.62	11.77	1.3	0.918
PITTSBURGH, PA	13.08	12.90	-1.4	1.005
PITTSFIELD, MA	12.35	12.56	1.8	0.979
PORTLAND, ME	10.85	12.29	13.2	0.958
PORTLAND, OR	10.17	12.90	26.9	1.006
PORTSMOUTH-DOVER-ROC	11.78	12.32	4.6	0.960
POUGHKEEPSIE, NY	13.07	13.08	0.1	1.020
PROVIDENCE, RI	11.09	12.65	14.1	0.986
PROVO-OREM, UT	10.63	12.24	15.2	0.954
PUEBLO, CO	10.17	12.70	25.0	0.990
RACINE, WI	10.84	12.88	18.9	1.004
RALEIGH-DURHAM, NC	11.82	12.15	2.8	0.947

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
RAPID CITY, SD	9.85	12.03	22.1	0.938
READING, PA	13.16	12.54	-4.7	0.978
REDDING, CA	12.70	13.16	3.6	1.026
RENO, NV	14.83	13.28	-10.4	1.036
RICHLAND-KENNEWICK-P	11.32	13.06	15.4	1.018
RICHMOND-PETERSBURG,	12.22	12.22	0.0	0.953
RIVERSIDE-SAN BERNAR	13.36	13.40	0.3	1.045
ROANOKE, VA	10.88	12.19	12.0	0.950
ROCHESTER, MN	10.43	12.61	20.9	0.983
ROCHESTER, NY	13.05	13.04	0.0	1.017
ROCKFORD, IL	13.18	12.73	-3.4	0.992
SACRAMENTO, CA	12.80	13.49	5.4	1.052
SAGINAW-BAY CITY-MID	11.15	13.28	19.1	1.035
SALEM, OR	10.89	12.61	15.8	0.983
SALINAS-SEASIDE-MONT	12.66	13.43	6.1	1.047
SALT LAKE CITY-OGDEN	10.63	12.52	17.8	0.976
SAN ANGELO, TX	12.96	11.85	-8.5	0.924
SAN ANTONIO, TX	13.17	12.12	-7.9	0.945
SAN DIEGO, CA	15.12	13.32	-11.9	1.038
SAN FRANCISCO, CA	13.08	14.05	7.5	1.095
SAN JOSE, CA	12.91	14.04	8.7	1.095
SANTA BARBARA-STA MA	15.48	13.34	-13.8	1.040
SANTA CRUZ, CA	12.66	13.30	5.1	1.037
SANTA FE, NM	13.38	12.59	-5.9	0.981
SANTA ROSA-PETALUMA,	13.18	13.38	1.5	1.043
SARASOTA, FL	13.15	12.51	-4.8	0.976

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
SAVANNAH, GA	13.41	12.18	-9.2	0.950
SCRANTON--WILKES-BAR	13.16	12.38	-5.9	0.965
SEATTLE, WA	11.02	13.22	20.0	1.031
SHARON, PA	12.69	12.53	-1.3	0.977
SHEBOYGAN, WI	10.46	12.23	16.9	0.954
SHERMAN-DENISON, TX	13.31	12.02	-9.7	0.937
SHREVEPORT, LA	13.22	12.57	-4.9	0.980
SIOUX CITY, IA-NE	9.53	12.29	28.9	0.958
SIOUX FALLS, SD	9.85	12.15	23.4	0.947
SOUTH BEND-MISHAWAKA	11.06	12.16	9.9	0.948
SPOKANE, WA	11.32	12.71	12.3	0.991
SPRINGFIELD, IL	13.32	12.86	-3.4	1.002
SPRINGFIELD, MA	12.35	12.54	1.6	0.978
SPRINGFIELD, MO	12.27	12.29	0.2	0.958
ST. CLOUD, MN	10.40	12.24	17.7	0.954
ST. JOSEPH, MO	7.57	12.18	60.8	0.950
ST. LOUIS, MO-IL	12.27	12.93	5.4	1.008
STATE COLLEGE, PA	12.69	12.41	-2.2	0.967
STEUBENVILLE-WEIRTON	13.66	12.52	-8.4	0.976
STOCKTON, CA	12.75	13.36	4.8	1.041
SYRACUSE, NY	13.07	12.64	-3.2	0.986
TACOMA, WA	10.82	13.01	20.3	1.015
TALLAHASSEE, FL	12.33	12.28	-0.4	0.957
TAMPA-ST. PETERSBURG	13.15	12.41	-5.7	0.967
TERRE HAUTE, IN	11.06	11.92	7.8	0.930
TEXARKANA, TX-TEXARK	13.31	11.91	-10.5	0.928

MSA	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
TOLEDO, OH	13.08	12.77	-2.3	0.995
TOPEKA, KS	12.43	12.25	-1.4	0.955
TRENTON, NJ	13.61	13.28	-2.4	1.035
TUCSON, AZ	12.85	12.69	-1.3	0.989
TULSA, OK	10.30	12.30	19.4	0.959
TUSCALOOSA, AL	11.54	12.17	5.5	0.949
TYLER, TX	13.31	12.17	-8.5	0.949
UTICA-ROME, NY	13.07	12.40	-5.1	0.967
VALLEJO-FAIRFIELD-NA	13.18	13.29	0.8	1.036
VANCOUVER, WA	10.82	12.85	18.8	1.002
VICTORIA, TX	13.76	12.12	-11.9	0.945
VINELAND-MILLVILLE-B	15.12	12.70	-16.0	0.990
VISALIA-TULARE-PORTE	13.62	12.94	-5.0	1.008
W PALM BCH-BOCA RATO	14.46	12.70	-12.2	0.990
WACO, TX	13.31	12.02	-9.7	0.937
WASHINGTON DC MD-VA	12.01	13.63	13.5	1.062
WATERLOO-CEDAR FALLS	9.87	12.42	25.8	0.968
WAUSAU, WI	10.76	12.33	14.6	0.961
WHEELING, WV-OH	13.66	12.34	-9.7	0.962
WICHITA FALLS, TX	12.96	11.98	-7.6	0.934
WICHITA, KS	12.43	12.46	0.2	0.971
WILLIAMSPORT, PA	13.16	12.37	-6.0	0.964
WILMINGTON, DE-NJ-MD	13.14	13.09	-0.4	1.020
WILMINGTON, NC	11.82	11.96	1.2	0.933
WORCESTER, MA	12.35	12.64	2.4	0.985
YAKIMA, WA	10.82	12.75	17.8	0.994
YORK, PA	12.69	12.46	-1.8	0.971

STATE=Alabama

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
BIRMINGHAM AL	11.25	12.20	8.5	0.951
MOBILE AL	11.44	12.07	5.5	0.941
NORTH CENTRAL AL	11.54	11.92	3.3	0.930
NORTHWEST AL	11.05	12.06	9.1	0.940
RURAL AL	10.99	11.90	8.2	0.927
SOUTHEAST AL	11.72	11.95	2.0	0.932

STATE=Alaska

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
ALASKA	16.32	14.68	-10	1.144

STATE=Arizona

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
FLAGSTAFF(CITY)AZ	11.80	12.37	4.8	0.964
PHOENIX(CITY)AZ	11.13	12.95	16.4	1.010
PRESCOTT(CITY)AZ	11.55	12.37	7.1	0.964
RURAL ARIZONA	12.93	12.53	-3.1	0.977
TUCSON(CITY)AZ	12.85	12.72	-1.0	0.992
YUMA(CITY)AZ	12.39	12.37	-0.2	0.964

STATE=Arkansas

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
ARKANSAS	11.62	11.62	0	0.906

36-375 0 - 90 - 6

STATE=California

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
ANAHEIM-SANTA ANA CA	15.72	14.18	-9.8	1.106
BAKERSFIELD CA	13.10	13.34	1.8	1.040
FRESNO-MADERA CA	12.60	13.00	3.1	1.013
KINGS-TULARE CA	13.62	12.91	-5.3	1.006
LOS ANGELES CA(1ST OF 8)	15.78	14.19	-10.1	1.106
LOS ANGELES CA(2ND OF 8)	15.92	14.19	-10.9	1.106
LOS ANGELES CA(3RD OF 8)	16.75	14.19	-15.3	1.106
LOS ANGELES CA(4TH OF 8)	15.71	14.19	-9.7	1.106
LOS ANGELES CA(5TH OF 8)	16.51	14.19	-14.1	1.106
LOS ANGELES CA(6TH OF 8)	16.68	14.19	-15.0	1.106
LOS ANGELES CA(7TH OF 8)	16.92	14.19	-16.2	1.106
LOS ANGELES CA(8TH OF 8)	16.60	14.19	-14.5	1.106
MARIN-NAPA-SOLANO CA	13.18	13.83	4.9	1.078
MERCED-SURR CNTYS CA	12.40	13.09	5.5	1.020
MONTEREY-SANTA CRUZ CA	12.66	13.54	6.9	1.055
N COASTAL CNTYS CA	12.17	13.23	8.7	1.032
NE RURAL CA	12.70	12.88	1.4	1.004
OAKLAND-BERKELEY CA	12.60	14.20	12.8	1.107
RIVERSIDE CA	13.74	13.45	-2.1	1.048
SACRAMENTO-SURR CNTYS CA	12.80	13.48	5.3	1.051
SAN BERNADINO-E CENTRAL	13.36	13.43	0.5	1.047
SAN DIEGO-IMPERIAL CA	15.12	13.49	-10.8	1.051
SAN FRANCISCO CA	13.08	14.47	10.7	1.128
SAN MATEO CA	12.71	14.47	13.8	1.128
SANTA BARBARA CA	15.48	13.31	-14.1	1.037
SANTA CLARA CA	12.91	14.48	12.1	1.129

STATE=California

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
STOCKTON-SURR CNTYS CA	12.75	13.17	3.3	1.027
VENTRUA CA	15.60	13.72	-12.0	1.070

STATE=Colorado

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
COLORADO	10.17	12.61	24	0.983

STATE=Connecticut

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
EASTERN CONN	14.53	13.01	-10.5	1.014
NW & N CENTRAL CONN	14.10	13.09	-7.2	1.021
SOUTH CENTRAL CONN	14.07	13.41	-4.7	1.045
SW CONNECTICUT	14.06	13.85	-1.5	1.080

STATE=Delaware

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
DELAWARE	13.14	12.92	-1.7	1.008

STATE=DC,MD & VA suburbs

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
DC + MD-VA SUBURBS	14.14	13.9	-1.7	1.084

STATE=Florida

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
FORT LAUDERDALE FL	14.46	12.79	-11.5	0.997
MIAMI FL	15.79	13.38	-15.3	1.043
N-NC FLORIDA CITIES	13.15	12.34	-6.1	0.962
RURAL FLORIDA	12.33	12.01	-2.6	0.936

STATE=Georgia

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
ATLANTA GA	12.33	12.59	2.1	0.982
RURAL GEORGIA	12.64	11.68	-7.6	0.911
SMALL GA CITIES 02	13.41	11.95	-10.9	0.932
SMALL GA CITIES 03	12.32	11.83	-3.9	0.922

STATE=Hawii

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
HAWAII	13.67	13.2	-3.4	1.029

STATE=Idaho

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
NORTH IDAHO	10.53	12.12	15.0	0.944
SOUTH IDAHO	9.93	12.22	23.1	0.953
cw hosp	10.66	12.19	14.4	0.950

STATE=Illinois

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
CHAMPAIGN-URBANA IL	13.71	12.22	-10.8	0.953
CHICAGO	14.44	13.88	-3.9	1.082
DE KALB IL	11.63	12.35	6.2	0.963
DECATUR IL	13.66	12.37	-9.4	0.965
EAST ST LOUIS IL	15.26	12.65	-17.1	0.986
KANKAKEE IL	14.11	12.30	-12.8	0.959
NORMAL IL	11.46	12.67	10.5	0.988
NORTHWEST IL	9.72	12.19	25.5	0.950
PEORIA IL	12.16	13.03	7.1	1.016
QUINCY IL	12.45	12.19	-2.1	0.950
ROCK ISLAND IL	13.59	12.50	-8.0	0.975
ROCKFORD IL	13.18	13.06	-0.9	1.018
SOUTHEAST IL	12.36	12.19	-1.4	0.950
SOUTHERN IL	18.10	12.19	-32.6	0.950
SPRINGFIELD IL	13.32	12.66	-4.9	0.987
SUBURBAN CHICAGO IL	12.56	13.48	7.3	1.051

STATE=Indiana

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
METROPOLITAN INDIANA	11.84	12.44	5.1	0.970
RURAL INDIANA	10.76	12.01	11.6	0.937
URBAN INDIANA	11.06	12.05	9.0	0.939

STATE=Iowa

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
DES MOINES (POLK-WARREN) I	9.48	12.49	31.6	0.973
IOWA CITY (CITY LIMITS)	13.23	12.21	-7.7	0.952
NORTH CENTRAL IOWA	9.87	12.08	22.4	0.942
NORTHEAST IOWA	9.34	12.09	29.5	0.943
NORTHWEST IOWA	9.53	11.96	25.5	0.932
S CEN IA (EXCL DES MOINES	9.90	11.87	19.9	0.925
SE IOWA (EXCL IOWA CITY)	10.49	12.19	16.2	0.950
SOUTHWEST IOWA	10.54	11.97	13.6	0.933

STATE=Kansas

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
KANSAS CITY KS	11.89	12.53	5.3	0.977
RURAL KANSAS	12.43	11.89	-4.3	0.927
SUBURBAN KANSAS CITY KS	11.75	12.53	6.6	0.977

STATE=Kentucky

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
LEXINGTON & LOUISVILLE K	11.64	12.18	4.7	0.950
RURAL KENTUCKY	10.33	11.94	15.6	0.931
SM CITIES (CITY LIMITS)	10.70	12.06	12.7	0.940

STATE=Louisiana

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
ALEXANDRIA LA	12.18	12.13	-0.4	0.946
BATON ROUGE LA	12.15	12.49	2.8	0.974
LAFAYETTE LA	12.53	12.26	-2.1	0.956
LAKE CHARLES LA	13.09	12.13	-7.4	0.945
MONROE LA	14.03	12.05	-14.1	0.939
NEW ORLEANS LA	13.62	12.81	-6.0	0.998
RURAL LOUISIANA	11.59	12.01	3.6	0.936
SHREVEPORT LA	13.22	12.48	-5.6	0.973

STATE=Maine

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
MAINE	10.85	11.98	10.4	0.934

STATE=Maryland

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
BALTIMORE-SURR CNTYS MD	14.04	13.15	-6.3	1.025
SOUTH + E SHORE MD	14.24	12.85	-9.8	1.001
WESTERN MARYLAND	12.97	12.83	-1.1	1.000

STATE=Massachusetts

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
MASS SUBURBS-RURAL(CITIE	13.33	13.00	-2.5	1.013
MASSACHUSETTS URBAN	12.35	13.28	7.6	1.035

STATE=Michigan

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
DETROIT MI	12.59	13.88	10.3	1.082
MICHIGAN NOT DETROIT	11.15	12.83	15.1	1.000

STATE=Minnesota

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
NORTHERN MINNESOTA	10.40	12.22	17.5	0.953
SOUTHERN MINNESOTA	9.39	12.11	28.9	0.944
ST PAUL-MINNEAPOLIS MN	10.43	12.89	23.6	1.005

STATE=Mississippi

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
RURAL MISSISSIPPI	11.12	11.67	4.9	0.909
URBAN MS(CITY LIMITS)	10.21	11.98	17.3	0.934

STATE=Missouri

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
K C (JACKSON COUNTY) MO	11.65	12.53	7.5	0.977
N K C (CLAY-PLATTE) MO	11.68	12.53	7.2	0.977
RURAL (EXCL RURAL NW) MO	11.14	11.83	6.2	0.922
RURAL NW COUNTIES MO	11.81	11.93	1.0	0.930
SM E CITIES + JEFF CNTY	10.23	12.30	20.1	0.959
ST JOSEPH MO	7.57	11.90	57.1	0.928
ST LOUIS-LG E CITIES MO	12.27	12.67	3.3	0.988

STATE=Montana

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
MONTANA	12.38	12.12	-2.2	0.944

STATE=Nebraska

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
OMAHA + LINCOLN NE	14.28	12.05	-15.6	0.939
RURAL NEBRASKA	12.22	11.58	-5.3	0.903
URBAN (CNTY POP>25000) N	12.33	11.67	-5.3	0.910

STATE=Nevada

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
ELKO & ELY (CITIES) NV	11.04	12.82	16.1	1.000
LAS VEGAS ET AL(CITIES)	15.26	13.46	-11.8	1.049
RENO ET AL (CITIES) NV	14.83	13.48	-9.1	1.051

STATE=New Hamphire

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
NEW HAMPSHIRE	11.78	12.39	5.2	0.966

STATE=New Jersey

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
MIDDLE NEW JERSEY	13.61	13.43	-1.3	1.047
NORTHERN NEW JERSEY	13.76	13.69	-0.5	1.067
SOUTHERN NEW JERSEY	15.12	13.20	-12.7	1.029

STATE=New Mexico

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
NEW MEXICO	13.38	12.24	-8.6	0.954

STATE=New York

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
BUFFALO-SURR CNTYS NY	10.36	12.57	21.3	0.980
MANHATTAN NY	14.98	14.61	-2.4	1.139
N CENTRAL CITIES NY	13.07	12.54	-4.0	0.977
NYC SUBURBS-LONG I NY	14.29	14.54	1.7	1.134
POUGHKPSIE-N NYC SUBURBS	12.86	12.96	0.8	1.010
QUEENS NY	14.29	14.61	2.2	1.139
ROCHESTER-SURR CNTYS NY	13.05	13.00	-0.4	1.013
RURAL NEW YORK	12.96	12.40	-4.3	0.966

STATE=North Carolina

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
NORTH CAROLINA	11.82	11.78	-0.3	0.918

STATE=North Dakota

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
NORTH DAKOTA	10.92	11.96	9.6	0.932

STATE=Ohio

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
AKRON OH	12.18	12.46	2.3	0.971
CINCINATI OH	13.33	12.48	-6.4	0.973
CLEVELAND OH	14.27	12.70	-11.0	0.990
COLUMBUS OH	13.28	12.43	-6.4	0.969
DAYTON OH	13.00	12.47	-4.1	0.972
E CENTRAL (STEUBENVL) OH	13.26	12.19	-8.1	0.950
MANSFIELD OH	12.15	12.14	-0.1	0.946
MARION + SURR CNTYS OH	12.59	12.15	-3.4	0.947
NORTHWEST (LIMA) OH	13.19	12.21	-7.4	0.952
SCIOTO VALLEY OH	11.72	12.31	5.0	0.960
SOUTHEAST (OHIO VALLEY)	13.40	12.13	-9.5	0.946
SPRINGFIELD OH	13.21	12.53	-5.2	0.977
TOLEDO (LUCAS-WOOD) OH	13.08	12.66	-3.2	0.987
W CENTR (LAKE PLAINS) OH	13.43	12.11	-9.8	0.944
YOUNGSTOWN OH	13.17	12.39	-5.9	0.966

STATE=Oklahoma

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
OK CITY ET AL (CITIES) O	10.01	12.21	21.9	0.952
RURAL OKLAHOMA	9.75	11.84	21.4	0.923
SM CITIES (NORTHERN) OK	9.53	11.78	23.5	0.918
SM CITIES (SOUTHERN) OK	10.68	11.78	10.4	0.918
TULSA ET AL (CITIES) OK	10.30	12.23	18.8	0.954

STATE=Oregon

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
EUGENE ET AL (CITIES) OR	9.56	12.55	31.3	0.979
PORTLAND ET AL (CITIES)	10.17	12.84	26.3	1.001
RURAL OREGON	10.66	12.58	18.1	0.981
SALEN ET AL(CITIES) OR	10.89	12.52	15.0	0.976
SW OR CITIES(CITY LIMITS	10.69	12.50	16.9	0.975

STATE=Pennsylvania

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
LG PENNSYLVANIA CITIES	13.16	12.97	-1.4	1.011
PHILLY-PITT MED SCHS-HOS	13.08	13.11	0.2	1.022
RURAL PENNSYLVANIA	12.24	12.30	0.5	0.959
SMALL PENNSYLVANIA CITIE	12.69	12.39	-2.4	0.966

STATE=Rhode Island

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
RHODE ISLAND	11.09	12.74	14.9	0.993

STATE=South Carolina

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
SOUTH CAROLINA	10.44	11.82	13.2	0.922

STATE=South Dakota

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
SOUTH DAKOTA	9.85	11.68	18.6	0.911

STATE=Tennessee

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
TENNESSEE	12.88	11.89	-7.7	0.927

STATE=Texas

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
AUSTIN TX	14.39	12.22	-15.1	0.953
DALLAS TX	13.89	12.44	-10.4	0.970
FORT WORTH TX	13.73	12.12	-11.7	0.945
HOUSTON TX	14.61	12.69	-13.2	0.989
NORTHEAST TEXAS	13.31	11.89	-10.7	0.927
SAN ANTONIO TX	13.17	12.09	-8.2	0.942
SOUTHEAST RURAL TEXAS	13.76	12.04	-12.5	0.938
STATEWIDE - TX	10.81	12.16	12.5	0.948
WESTERN RURAL TEXAS	12.96	11.87	-8.4	0.925

STATE=Utah

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
UTAH	10.63	12.42	16.9	0.969

STATE=Vermont

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
VERMONT	11.59	11.91	2.8	0.929

STATE=Virginia

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
RICHMOND+CHARLOTTESVL VA	12.01	12.20	1.6	0.951
RURAL VIRGINIA	12.22	11.88	-2.8	0.926
SM TOWN-INDUSTRIAL VA	10.88	11.93	9.7	0.930
TIDEWATER+N VA COUNTIES	12.43	12.56	1.0	0.979

STATE=Washington

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
E CEN+NE WA (EXCL SPOKAN	10.98	12.64	.	.
SEATTLE (KING CNTY) WA	11.02	13.15	19.3	1.025
SPOKANE+RICHLND(CITIES)W	11.32	12.76	12.8	0.995
W + SE WA (EXCL SEATTLE)	10.82	12.83	18.6	1.000

STATE=West Virginia

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
CHARLESTON WV	13.96	12.40	-11.2	0.967
EASTERN VALLEY WV	13.19	11.88	-9.9	0.926
OHIO RIVER VALLEY WV	12.88	11.88	-7.8	0.926
SOUTHERN VALLEY WV	13.10	11.83	-9.7	0.923
WHEELING WV	13.66	12.07	-11.7	0.941

STATE=Wisconsin

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
CENTRAL WISCONSIN	13.12	11.87	-9.5	0.926
GREEN BAY WI (NORTHEAST)	12.18	12.12	-0.5	0.945
JANESVILLE WI (S-CENTRAL	10.52	12.01	14.2	0.936
LA CROSSE WI (W-CENTRAL)	11.15	12.12	8.7	0.945
MADISON WI (DANE COUNTY)	10.05	12.38	23.2	0.966
MILWAUKEE SUBURBS WI (SE	10.84	12.75	17.7	0.994
MILWAUKEE WI	10.54	12.74	20.9	0.994
NORTHWEST WISCONSIN	10.48	11.99	14.4	0.935
OSKOSH WI (E-CENTRAL)	10.46	12.07	15.3	0.941
SOUTHWEST WISCONSIN	12.49	11.87	-4.9	0.926
WAUSAU WI (N-CENTRAL)	10.76	11.99	11.4	0.935

STATE=Wyoming

locality	1990 conversion factor	ultimate conversion factor	percent change from current	GPCI (US average=1)
WYOMING	11.03	12.29	11.4	0.958

Mr. WAXMAN. Dr. Stephenson, as you know, we included changes in the methods for determining payments for medical direction for anesthesia services when two or more concurrent procedures are undertaken.

What effect have you seen on the use of nurse anesthetists as a result of these changes?

Ms. STEPHENSON. We did a survey completed last year in which we have seen a decrease in the number of nurse anesthetists directed by anesthesiologists.

Mr. WAXMAN. Dr. Rogers, as I understand your testimony, ACR believes proposed reductions of radiology conversion factors would occur too rapidly under the proposal advanced by the PPRC. Your plan for reducing wide variation in local conversion factors for radiology would take place over a 6-year period.

Do I understand your position correctly?

Mr. ROGERS. That is correct.

Mr. WAXMAN. Could you also estimate what percentage reduction would occur in Medicare payments for radiology in 1991 under your proposed phase-in of geographic adjustments?

Mr. ROGERS. We would phase it over a 5-year period, which would be a third. I cannot give you a dollar figure.

Mr. WAXMAN. If you can give us that for the record?

Mr. ROGERS. I cannot give you a dollar figure. I don't know one for certain. I would just as soon not estimate. I don't know.

Mr. WAXMAN. Let me thank both of you for your testimony.

Mr. ROGERS. We will submit that at a later date.

Mr. WAXMAN. Sure. We were pleased to hear from you today, and we look forward to working with you.

Our final witness today represents over 2,000 suppliers of home medical equipment and the wholesalers and retailers of these products. I want to welcome Jeremy Jones, president and CEO of Homedco, Inc., a national provider of home medical equipment.

Mr. Jones is representing the National Association of Medical Equipment Suppliers and the Health Industry Distributors Association. Mr. Jones, your statement will be made a part of the record in full.

STATEMENT OF JEREMY M. JONES, PRESIDENT, HOMEDCO, INC., ON BEHALF OF THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS AND HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

Mr. JONES. Thank you, Mr. Chairman.

I am grateful to be here today and appreciate the interest the committee has shown. My name is Jeremy Jones. I am president of Homedco; we are 190 million, national provider of infusion, respiratory and home medical services.

We are proud to be the first provider in the United States to go through the JCHO certification process for the home care community. I am representing the National Association of Medical Equipment Suppliers and the Health Industry Distributors Association, as well as 2,000 independent and ethical providers of home medical equipment.

If I may, I would like to review historically the impact of legislation and regulatory changes on our industry, since 1985, which have been extensive.

We received a 1.7 percent CPI increase over the last 6 years. And in 1987, OBRA 87 was passed, which was a payment reform known as the six-point plan.

The plan was initiated by the Energy and Commerce Subcommittee. We believe it was well-conceived and the committee deserves to be complimented for their view of the future.

We also believe the program deserves a right to be implemented to produce the results which were recognized at the time it was conceived. The plan was initially implemented as part of the home medical equipment benefit in January 1989, and the initial savings in the first year were $161 million. That is $100 million greater than CBO's estimate during the initial projections.

The oxygen implementation program started in June 1989, and produced a 20 percent reduction in oxygen reimbursing during the first fee screen development. These numbers are produced as a direct result of an industry study commissioned by Lewin/ICF, which has analyzed the impact of the home medical equipment industry over the past few years.

The administration is proposing in their fiscal year 1991 budget to reduce current reimbursement levels by $255 million, which represents 13 percent of the total base of HME expenditures. CBO's revised estimate was $310 million, and the Lewin/ICF suggests that the administration's proposal will cut $500 million from the home medical equipment benefit. That represents 25 percent of the total base line of current expenditures for home medical equipment.

Proportionately, our industry represents only 2 percent of all Medicare expenditures. And if the Lewin projections are accurate, as we believe they are, the administration's proposal will in fact force the HME industry to absorb better than 10 percent of the total cuts in the Medicare budget for next year.

If current reports are accurate, that $6 billion may in fact be the provider Medicare cut in the coming budget year, providers not only in the home medical equipment industry, but all of health care will continually find it difficult to provide access and service on an ongoing basis to needy beneficiaries.

The administration's perception is home medical equipment benefit is, in fact, growing. However, CBO's own estimate, there has only been a 1.7 percent increase in price that occurred in 1987. No increases are projected in price in 1989 and 1990, while better than 5 percent utilization is projected by CBO.

The HME industry is growing. However, it is growing to an—due to aging population and the incentives created by DRG's, and the fact the home environment is the lowest cost alternative to take care of health care-dependent individuals.

The Lewin report confirms that the price is not growing for the durable medical services we provide. The increase is due to utilization, not to price increases.

I would like to address the GAO's testimony before the Ways and Means Committee in May. They stated there was wide price variation that was unexplainable. They failed, however, to discuss the

impact of regionalization, which is part of the six-point plan. They had not modeled the impact on pricing, and when questioned, they indicated that their projections would be available in December 1990.

They did not know of any future savings that were projected as part of OBRA 87, and when pressed by Congressman Gradison, they failed to endorse the national fee screens that have been proposed by the administration.

Our industry has in fact modeled the six-point plan through the Lewin study. The six-point plan was designed to create consistent pricing, and to recognize regional variations that exist in the providing of home medical equipment services.

In the 3 years including 1989, 1990, and 1991, the actual savings will be $515 million, compared to the CBO's estimate of $265 million, or a $250 million variance between what CBO actually estimated.

I guess I would like to ask the committee to have CBO review the Lewin report, and try and revise their estimates so that the industry can truly be acknowledged for the amount of contribution we have contributed over the past year.

The study is available. We will make it available to all of the committee to review. In closing, OBRA 87 represented payment reform for the home medical equipment industry, it has been in place for approximately 12 to 18 months, and the regionalization of pricing will occur January 1 of this year.

It is designed to create consistency, and over a 5-year period, through 1993, it will save $950 million, and it reflects the nature of the local business. Our industry is prepared to contribute to the deficit area in fiscal year 1991; however, we believe it needs to be done through across-the-board budget cuts, but through intelligent selection of priorities in how to reduce expenditures.

If our industry is forced to go through continuous cuts, it will limit our ability to meet beneficiaries' future needs. And it forces us to be selective about the services we offer and eventually will reduce access to health care.

I thank the committee for hearing me today. Our industry is prepared to contribute on a proportional basis to the reduction in health care expenditures in the coming year. We believe we had paid our pew rent. We also believe we need a CPI increase to continue to serve the beneficiaries and the growing utilization.

Mr. Chairman, I thank you for the leadership you have provided in the past, and we look forward to working with you in the future.

[Testimony resumes on p. 241.]

[The prepared statement and attachments of Mr. Jones follow:]

TESTIMONY

OF

JEREMY M. JONES
PRESIDENT AND CEO,
HOMEDCO, INC.

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS JEREMY M. JONES. I AM PRESIDENT AND CEO OF HOMEDCO, INC., A NATIONAL PROVIDER OF HOME MEDICAL EQUIPMENT (HME). I AM PLEASED FOR THIS OPPORTUNITY TO SPEAK WITH YOU ABOUT THE IMPACT ON THE HME INDUSTRY OF THE ADMINISTRATION'S PROPOSED FISCAL YEAR (FY) 1991 BUDGET.

I AM TESTIFYING ON BEHALF OF TWO NATIONAL TRADE ASSOCIATIONS REPRESENTING THE HME INDUSTRY, THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS (NAMES) AND THE HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION (HIDA). NAMES IS A NONPROFIT ASSOCIATION COMPOSED OF 2000 SUPPLIERS OF HOME MEDICAL EQUIPMENT WHO TAKE PRIDE IN THE SERVICES THEY PROVIDE TO THEIR COMMUNITY. UPON PHYSICIANS' ORDERS, NAMES MEMBERS PROVIDE A WIDE VARIETY OF EQUIPMENT, SUPPLIES AND MEDICAL SERVICES FOR HOME USE. HIDA REPRESENTS MORE THAN 700 WHOLESALERS AND RETAILERS SERVING THE NATION'S HOSPITALS, NURSING HOMES, PHYSICIANS, CLINICS, HOME CARE PATIENTS AND OTHER USERS OF MEDICAL SUPPLIES AND EQUIPMENT. THE HME SUPPLIED BY MEMBERS OF THESE ASSOCIATIONS INCLUDES TRADITIONAL ITEMS SUCH AS WHEELCHAIRS AND HOSPITAL BEDS, AND HIGHLY TECHNICAL MODALITIES AND SERVICES SUCH AS SPECIALIZED REHABILITATION AND LIFE SUSTAINING DEVICES.

THE MISSION OF THE HME PROVIDERS WHO ARE REPRESENTED BY NAMES AND HIDA IS TO PROVIDE HIGH QUALITY, COST EFFECTIVE HEALTH CARE SERVICES TO PEOPLE IN THEIR OWN HOMES SO THAT THEY MAY MAINTAIN THEIR INDEPENDENCE AND DIGNITY AND THUS ENJOY A BETTER QUALITY OF LIFE, IN THE LOWEST COST ENVIRONMENT.

IN 1987, THIS COMMITTEE SPENT NEARLY A YEAR SERIOUSLY RETHINKING THE ROLE OF HME UNDER MEDICARE. IT WAS THE FIRST CAREFUL ANALYSIS OF THE INDUSTRY SINCE 1965. THE RESULT WAS A MAJOR AND WISE REVISION OF HME REIMBURSEMENT ENACTED AS PART OF OBRA '87. TODAY, HOWEVER, A SCANT THREE YEARS LATER, THE COMMITTEE'S THOUGHTFUL AND PRINCIPLED WORK IS IN JEOPARDY.

ALTHOUGH IT HAS BEEN DOCUMENTED THAT PEOPLE WOULD RATHER BE CARED FOR IN THE HOME AND THAT HOSPITAL AND NURSING HOME COSTS FAR EXCEED COSTS OF ALTERNATIVE CARE IN THE HOME, THE ADMINISTRATION CONTINUES TO TARGET THE HME INDUSTRY FOR DISPROPORTIONATE BUDGET REDUCTIONS. THIS ADMINISTRATION, WHOSE HEALTH POLICIES ARE BUDGET DRIVEN, SIMPLISTICALLY VIEWS HOME HEALTH EQUIPMENT AS A "GROWTH INDUSTRY" AND THUS A TARGET FOR FURTHER COST CUTTING. THE ADMINISTRATION FAILS TO UNDERSTAND THE CAUSE OF THAT GROWTH AND THE NET EFFECT OF CONTINUOUS BUDGET REDUCTIONS ON OUR INDUSTRY'S ABILITY TO PROFESSIONALLY SERVE AND FINANCE THE ADDITIONAL NEEDS OF MEDICARE BENEFICIARIES.

INDEED, THE HME INDUSTRY IS GROWING. BUT THE GROWTH IS IN PATIENT NEEDS -- NOT INCREASED REIMBURSEMENT. IN FACT, A RECENT STUDY BY LEWIN/ICF -- DISCUSSED LATER -- SHOWS THAT PER ITEM REIMBURSEMENT ACTUALLY HAS DECLINED SINCE 1987. THUS, ANY GROWTH IN HME OUTLAYS IS NOT DUE TO REIMBURSEMENT, BUT RATHER TO MORE PEOPLE BECOMING MEDICARE ELIGIBLE -- THOSE PEOPLE REACHING THE AGE OF 65 HAVE AN EXTENDED LIFE EXPECTANCY. FOR MEN AGED 65, THE LIFE EXPECTANCY IS 81 YEARS; FOR WOMEN, 86 YEARS. AS SUCH, MORE PEOPLE ARE

TAPPING INTO MEDICARE BENEFITS FOR A LONGER PERIOD OF TIME. SINCE 1983, THROUGH THE PROSPECTIVE PAYMENT SYSTEM (PPS), MEDICARE IS PRESSURING HOSPITALS TO DISCHARGE PATIENTS EARLIER AND OFTEN SICKER THAN BEFORE. NEW TECHNOLOGIES SUCH AS VENTILATORS, NUTRITIONAL FEEDINGS AND CHEMOTHERAPY RECENTLY HAVE BEEN DEVELOPED WHICH MAKES THIS ALL POSSIBLE.

DURING THE LAST 10 YEARS, ONLY 130,000 NEW NURSING HOME BEDS HAVE BEEN BUILT; THAT IS AN INCREASE OF 9% OVER 10 YEARS. THE AVERAGE OCCUPANCY RATE OF NURSING HOMES IS 95%. IF HOSPITALS MUST DISCHARGE EARLIER AND NURSING HOME BEDS ARE UNAVAILABLE, WHERE ARE PATIENTS TO GO BUT TO THEIR HOMES. TAKING CARE OF MORE MEDICARE BENEFICIARIES AT HOME OBVIOUSLY INCREASES HOME CARE OUTLAYS -- BUT IT ALSO SIMULTANEOUSLY REDUCES INSTITUTIONAL HEALTH CARE EXPENDITURES.

UNDER THIS COMMITTEE'S WORK IN 1987, HME INDUSTRY REIMBURSEMENT FOR INDIVIDUAL PIECES OF EQUIPMENT INCLUDES ALL THE SERVICES PROVIDED WITH THAT EQUIPMENT. NO SEPARATE PAYMENT FOR RELATED SERVICES IS PROVIDED. THESE SERVICES INCLUDE, FOR EXAMPLE, DELIVERY OF EQUIPMENT, SET-UP, PATIENT AND FAMILY EDUCATION, CLAIMS PROCESSING, ROUTINE MONITORING, AND MAINTENANCE, SERVICING AND REPLACEMENT EVEN WHEN EQUIPMENT IS LOST OR ABUSED. ADMINISTRATION EFFORTS TO SET REIMBURSEMENT AMOUNTS THAT ONLY ADDRESS EQUIPMENT ACQUISITION COSTS ARE INAPPROPRIATE. AS THIS COMMITTEE RECOGNIZED, THE MEDICARE HME BENEFIT IS ABSOLUTELY DEPENDENT ON SUPPORT SERVICES.

MOST PATIENTS WITH HOMECARE EQUIPMENT ARE SEEN BY NO OTHER HEALTH CARE PROVIDER IN THE HOME, OTHER THAN THE REPRESENTATIVE FROM THE HME PROVIDER. IT IS THE QUALITY-CONSCIENCE HME EMPLOYEE WHO IS ALERT TO CHANGES IN PATIENTS' CONDITIONS AND WHO COMMUNICATES THESE CHANGES TO THE PRESCRIBING PHYSICIAN. THIS MONITORING AND COMMUNICATION RESPONSIBILITY IS A REQUIREMENT OF THE JOINT COMMISSION (JCAHO) ACCREDITATION STANDARDS AND THE COMMUNITY HEALTH ACCREDITATION PROGRAM, WHICH OUR INDUSTRY ENTHUSIASTICALLY HAS ENDORSED.

AS REIMBURSEMENT FOR EQUIPMENT HAS DECLINED OVER THE LAST SIX YEARS, OPERATING EXPENSES HAVE CONTINUED TO RISE. WAGES AND BENEFITS OF MEDICAL PROFESSIONALS, OTHER LABOR COSTS, PLUS OPERATING COSTS SUCH AS AUTOMOBILE AND PRODUCT LIABILITY INSURANCE, RENT AND GASOLINE HAVE RISEN BETTER THAN 20% OVER THE PAST 5 YEARS. THE NET EFFECT OF GREATER DEMAND, REDUCED REIMBURSEMENT AND HIGHER OPERATING COSTS HAS CAUSED THE HME INDUSTRY TO STRUGGLE TO MEET THE NEEDS OF MEDICARE AND MEDICAID BENEFICIARIES WITH THE LIMITED FUNDS AVAILABLE.

BEFORE DISCUSSING THE ADMINISTRATION'S SPECIFIC HME BUDGET PROPOSALS FOR FISCAL YEAR 1991, I WOULD LIKE TO HIGHLIGHT THE REDUCTIONS PREVIOUSLY ABSORBED BY THE HME INDUSTRY OVER THE PAST 6 YEARS, INCLUDING THOSE RESULTING FROM THIS COMMITTEE'S WORK IN OBRA '87. IT IS BENEFICIAL TO HIGHLIGHT THE PREVIOUS REDUCTIONS ABSORBED BY THE HME INDUSTRY SO THAT THE FULL CUMULATIVE EFFECT OF THE ADMINISTRATION'S PROPOSALS CAN BE APPRECIATED. THE PRESIDENT'S BUDGET REDUCTIONS FOR HME WILL NOT TAKE PLACE IN A VACUUM.

SINCE 1984, HME SERVICES HAVE RECEIVED A SINGLE CONSUMER PRICE INDEX (CPI) UPDATE -- 1.7% ON JANUARY 1, 1987. YET DURING THIS SAME TIME PERIOD, GRAMM-RUDMAN REDUCTIONS TO HME SERVICES OCCURRED (1986, 1988, AND 1990); LOWEST CHARGE LEVELS (LCL) FURTHER REDUCED REIMBURSEMENT (1987); AND OXYGEN PAYMENT WAS REDUCED UP TO 30% (JUNE 1, 1989). APPLICATION OF INFLATION-INDEX CHARGES BASED UPON 1983 CHARGES (AND SUBSEQUENT LOWER CHARGES) ALSO REDUCED HME PAYMENTS (1986).

AS RECENTLY AS LAST YEAR, THE HME INDUSTRY EXPERIENCED REDUCTIONS OF AT LEAST $80 MILLION IN MEDICARE HME PROGRAM EXPENDITURES. THIS WAS ACHIEVED BY REDUCING REIMBURSEMENT FOR SEAT-LIFT CHAIRS AND TENS BY 15%; CAPPING REIMBURSEMENT FOR ENTERAL EQUIPMENT AT 15 MONTHS; AND ELIMINATING THE CONSUMER PRICE INDEX (CPI) UPDATE. IN CONJUNCTION WITH THIS, THE HME INDUSTRY ALSO EXPERIENCED GRAMM-RUDMAN REDUCTIONS OF 2.092% FROM OCTOBER 1, 1989 TO MARCH 31, 1990 AND 1.42% FROM APRIL 1, 1990 TO SEPTEMBER 30, 1990.

PREMIER NATIONAL HEALTH POLICY ANALYST DR. ROBERT RUBIN, PRESIDENT OF HEALTH & SCIENCES INTERNATIONAL, PARENT COMPANY OF LEWIN/ICF, RECENTLY COMPLETED AN EXHAUSTIVE ANALYSIS OF THE POLICY CHANGES IN MEDICARE, THAT HAVE HAD A SIGNIFICANT IMPACT ON THE HME INDUSTRY. ENTITLED "ANALYSIS OF THE IMPACT OF REIMBURSEMENT CHANGES ON THE HOME MEDICAL EQUIPMENT (HME) INDUSTRY", THE STUDY COMPARED PAYMENTS IN FISCAL YEARS 1989 THROUGH 1993 UNDER CURRENT POLICY TO PAYMENTS THAT WOULD HAVE BEEN MADE HAD NO CHANGES OCCURRED -- SPECIFICALLY, THE MAJOR LEGISLATIVE CHANGES OF THE SIX POINT PLAN AND OBRA '89 PLUS

NUMEROUS LESSER-KNOWN MODIFICATIONS IN THE RULES USED BY HCFA CONTRACTORS TO MAKE PAYMENTS TO HME SUPPLIERS.

KEY FINDINGS INCLUDE:

- AVERAGE REIMBURSEMENT FOR HME ON A PER ITEM BASIS HAS DECREASED AND HAS BEEN SET AT LOWER LEVELS THAN IN PRECEDING YEARS.
- INCREASES IN THE POPULATIONS REQUIRING HOME HEALTH SERVICES MEAN THAT MORE SERVICES WILL BE NEEDED.
- REIMBURSEMENTS UNDER OBRA '87 AND '89 ARE SUBSTANTIALLY LOWER THAN THE ESTIMATES MADE BY THE CONGRESSIONAL BUDGET OFFICE AT THE TIME OF ENACTMENT.
- UNDER THE SIX POINT PLAN, WHICH WAS DESIGNED TO RECOGNIZE DIFFERENT CATEGORIES OF HOME MEDICAL EQUIPMENT AND REIMBURSE FOR EACH APPROPRIATELY, AVERAGE PAYMENTS ACTUALLY DECLINED FOR THREE TYPES OF ESSENTIAL PRODUCTS.
- UNDER THE SIX POINT PLAN, PAYMENT AMOUNT VARIATION FOR THE THREE MAJOR PRODUCT TYPES WILL BE FURTHER REDUCED DUE TO THE PHASE IN OF REGIONAL FEE SCHEDULES WITHIN NATIONAL LIMITS.
- THE ADMINISTRATION'S PROPOSED PLAN FOR FY 1991 WOULD ESTABLISH NATIONAL PRICING AND THUS FAILS TO RECOGNIZE LOCAL AND REGIONAL VARIATIONS IN THE COST OF PROVIDING HOME MEDICAL EQUIPMENT.

ONE FINAL POINT -- THE HME INDUSTRY REPRESENTS JUST 2% OF TOTAL MEDICARE OUTLAYS. YET, THE ADMINISTRATION HAS PROPOSED CUTS TO HME EXPENDITURES OF OVER $250 TO $320 MILLION FOR FY 1991, REPRESENTING AN 11.6% REDUCTION IN HME EXPENDITURES. INTERESTINGLY, IN THE MAY 15, 1990 HEALTH SECTION OF THE WASHINGTON POST, THE PRESIDENT IS QUOTED AS SAYING: "I BELIEVE WE NEED MORE HOME CARE AS OPPOSED TO MANDATE HOSPITALIZATION." REDUCTIONS OF $250 - $320 MILLION IN HOME MEDICAL EQUIPMENT WOULD NOT SERVE THIS GOAL ARTICULATED SO WELL BY

THE PRESIDENT. THE HME INDUSTRY HAS CONTRIBUTED MORE THAN OUR SHARE OVER THE PAST 6 YEARS AND WE URGE THAT REDUCTIONS FOR HME IN FY 1991 BE PROPORTIONAL TO ITS SHARE OF THE MEDICARE BUDGET.

THE FOLLOWING SPECIFICALLY ADDRESSES SOME OF THE ADMINISTRATION'S BUDGET REDUCTION PROPOSALS AS THEY RELATE TO THE HME INDUSTRY.

A. NATIONAL CAP ON FEE SCHEDULES

PROPOSAL:

THE ADMINISTRATION PROPOSAL REPEALS THE CURRENT LAW (SIX POINT PLAN OF OBRA '87) WHICH IMPLEMENTS REGIONAL FEE SCHEDULES WITHIN ALLOWED NATIONAL LIMITS IN VARIATION, AND IMPOSES A NATIONAL CAP AT THE MEDIAN OF ALL LOCAL FEE SCHEDULES. IN ADDITION, LOCAL FEE SCHEDULES AT OR ABOVE THE NATIONAL CAP WOULD NOT RECEIVE ANY CPI UPDATE.

RESPONSE:

THE SIX POINT PLAN FEE SCHEDULE SYSTEM FOR HME REIMBURSEMENT WAS DRAFTED BY THIS COMMITTEE AND ADOPTED AS PART OF OBRA '87. THIS MAJOR REFORM LEGISLATION, WHICH COMPLETELY REVISED HME REIMBURSEMENT RULES, WAS IMPLEMENTED IN JANUARY AND JUNE OF 1989. AS PART OF THIS REFORM, THE SIX POINT PLAN WILL PHASE-IN REGIONAL FEE SCHEDULES FOR OXYGEN AND MOST RENTAL ITEMS BEGINNING JANUARY 1991. THE REGIONAL

FEE SCHEDULE AMOUNTS WILL BE REDUCED FURTHER THROUGH A PROCESS OF LIMITS BASED ON ALLOWED NATIONAL VARIATION, PHASED IN DURING 1991 AND 1992.

THE ADMINISTRATION'S PROPOSAL ABANDONS THIS PHASED IMPLEMENTATION OF A NATIONAL PRICING SYSTEM THAT ALLOWS FOR SLIGHT REGIONAL VARIATIONS TO ACCOUNT FOR DIFFERING COSTS OF DOING BUSINESS IN DIFFERENT AREAS OF THE COUNTRY. IN ITS PLACE, THE ADMINISTRATION SUBSTITUTES A PATENTLY INAPPROPRIATE SYSTEM OF FLAT NATIONAL PRICES IRRESPECTIVE OF WHETHER THE PATIENT RESIDES IN RURAL KANSAS OR URBAN CALIFORNIA. THE HME INDUSTRY STRONGLY OBJECTS TO SUCH A CHANGE AND CONTINUES TO SUPPORT THE LAW THIS COMMITTEE DRAFTED IN 1987.

THE HME INDUSTRY UNDERSTANDS THAT VARIATIONS IN PAYMENT LEVELS BY PRODUCTS CURRENTLY EXIST AMONG CARRIERS UNDER THE SIX POINT PLAN. THAT WAS EXPECTED. THE POLICY ISSUE, HOWEVER, REMAINS WHY THESE VARIATIONS EXIST AND HOW THEY CAN BE RESOLVED EQUITABLY. THE REPORTED VARIATIONS IN PRICING AMONG CARRIERS EXIST FOR SEVERAL REASONS, ALL OF WHICH ARE NOT UNDER THE CONTROL OF SUPPLIERS, NAMELY: UNIQUE LABOR AND OTHER OPERATIONAL COSTS IN DIFFERENT LOCALITIES AND HISTORICALLY BAD CARRIER DATA.

REAL VARIATIONS IN BUSINESS COSTS IN DIFFERENT STATES ARE FACTORS THAT MUST BE CONSIDERED. THE HME INDUSTRY IS INHERENTLY A LOCAL, SERVICE INTENSIVE INDUSTRY. THE COSTS OF PROVIDING HME SERVICES ARE DRIVEN BY LOCAL FACTORS; SERVICE REQUIREMENTS ARE DICTATED BY LOCAL

MEDICAL PRACTICES AND STATE AND FEDERAL REGULATIONS, INCLUDING THOSE PROMULGATED BY DOT, FDA, CDC, AND THE EPA.

FURTHER, THIS INDUSTRY IS DOCUMENTED TO BE HIGHLY LABOR INTENSIVE, SINCE EMPLOYEES MUST: (1) SELECT THE APPROPRIATE ITEM TO MEET THE PHYSICIAN'S PRESCRIPTION; (2) DELIVER AND SET-UP THE ITEM; (3) TRAIN THE PATIENTS, FAMILY, AND/OR OTHER CAREGIVERS (I.E. HOME HEALTH NURSES) IN ITS APPROPRIATE USE; (4) PROVIDE 24-HOUR EMERGENCY SERVICE 7 DAYS PER WEEK IN THE EVENT OF EQUIPMENT MALFUNCTION; (5) REGULARLY SERVICE, REPAIR, OR REPLACE THE ITEM DURING THE PERIOD OF NEED; (6) REMOVE THE ITEM WHEN NEED CEASES; AND (7) DEVELOP, IMPLEMENT AND MONITOR EXTRAORDINARY CLAIMS PROCESSING REQUIREMENTS FOR BOTH ASSIGNED AND NONASSIGNED CLAIMS.

WAGES AND BENEFITS ALSO ARE BASED UPON LOCAL VARIABLES AND REPRESENT MORE THAN 60 PERCENT OF TOTAL EXPENSES FOR MANY HME INDUSTRY SITES, ACCORDING TO SEVERAL NATIONAL HME COMPANIES. OTHER OPERATIONAL COSTS SUCH AS OFFICE SPACE, GASOLINE, VEHICLE AND PRODUCT LIABILITY INSURANCE AND UTILITIES VARY ENORMOUSLY FROM ONE STATE TO ANOTHER. THE CONGRESS, IN ENACTING THE SIX POINT PLAN, RECOGNIZED THAT THESE COSTS OF PROVIDING HME SERVICES VARY BY GEOGRAPHIC AREA AND APPROPRIATELY ACCOUNTS FOR THIS FACT IN ITS PHASED-IN PROGRAM OF REGIONAL PRICING SUBJECT TO NATIONAL LIMITS. BECAUSE THE HME INDUSTRY IS LABOR-INTENSIVE AND COSTS HAVE RISEN, IT IS ESSENTIAL TO RECEIVE A CPI UPDATE IN FY 1991.

SOME VARIATIONS IN FEES MAY BE ACTUAL VARIATIONS CAUSED BY VARYING MEDICAL PRACTICES IN THE COMMUNITY -- PHYSICIANS MAY VERY WELL ORDER ONE TYPE OF PRODUCT, WHICH HAS A HIGHER PRICE, OVER ANOTHER. THROUGH THE IMPLEMENTATION IN THE EARLY 1980'S OF A NATIONAL SYSTEM OF BILLING CODES (HCPCS), INDIVIDUAL CARRIERS MANAGED A TRANSITION FROM THEIR UNIQUE LOCAL CODING SYSTEM TO THE NATIONAL HCPCS. THIS TRANSITION HAD THE EFFECT OF CONSOLIDATING AND UNIFYING VARIATIONS IN PHYSICIAN PRESCRIBING OVER A PERIOD OF TIME WITHIN EACH CARRIER FOR HME IDENTIFIED WITH A HCPCS.

WHILE THIS NARROWING OF VARIATION IN PHYSICIAN PRESCRIBING (AND CONSEQUENTLY CARRIER PRICING AND PAYMENT) OCCURRED WITHIN CARRIERS, IT DID NOT OCCUR BETWEEN CARRIERS. FOR EXAMPLE, A PHYSICIAN PRESCRIBING VENTILATOR MAY IN ONE AREA DEMAND THAT THE HME SUPPLIER INCLUDE A BACK-UP VENTILATOR AND ONGOING RESPIRATORY THERAPIST DURING THE PERIOD OF NEED, WHILE A PHYSICIAN AT A SECOND AREA MAY REQUIRE THE ONGOING RESPIRATORY THERAPIST, BUT NO BACK-UP. FOR EACH OF THESE AREAS, DIFFERENT CARRIERS USE THE SAME HCPCS, BUT THERE IS WIDE VARIATION IN REIMBURSEMENT AMOUNTS DUE TO THE VARIATION IN PHYSICIAN PRESCRIBING.

INDIVIDUAL CARRIERS HAVE MANAGED THE VARIATION TRANSITION WITHIN THE CARRIER BUT HCFA HAS NOT DIRECTED OR OVERSEEN ANY SIMILAR TRANSITIONS BETWEEN CARRIERS. THUS, THE CURRENT HCPCS SYSTEM WILL INHERENTLY INCLUDE WIDE VARIATIONS IN REIMBURSEMENT BETWEEN CARRIERS BECAUSE OF THE WIDE VARIATION IN PRODUCT AND SUPPORT SERVICES PHYSI-

CIANS DEMAND BY PRESCRIPTION. IF, DUE TO PHYSICIAN PREFERENCE, ONE PARTICULAR PRODUCT DOMINATES THE MARKETPLACE, THE HISTORICAL USE OF CUSTOMARY CHARGES WILL BEGIN TO TRACK ALONG WITH THE ROUTINE BILLS.

OTHER ACTUAL VARIATIONS MAY BE CAUSED IN PART BY DIFFERENT CHARGE HISTORIES AMONG CARRIERS THAT EVOLVED OVER THE TWENTY YEARS DURING WHICH THE "REASONABLE CHARGE" REIMBURSEMENT SYSTEM (WITH ITS MULTIPLE METHODS AND WIDE CARRIER DISCRETION IN CALCULATING REIMBURSEMENT) WAS REQUIRED BY THE MEDICARE LAW.

THE SIX POINT PLAN WAS IN PART SUPPORTED BY THE HME INDUSTRY TO CORRECT THESE PROBLEMS CONTRIBUTING TO UNEXPLAINED VARIATIONS IN REIMBURSEMENT FROM CARRIER TO CARRIER. MORE IMPORTANTLY, THE RECENT LEWIN/ICF STUDY DOCUMENTS THAT REIMBURSEMENT VARIATIONS FROM LOCALITY TO LOCALITY WILL BE DRAMATICALLY REDUCED IF CONGRESS WILL LET OBRA '87 BE IMPLEMENTED AS ENVISIONED BY THIS COMMITTEE.

FURTHERMORE, ALL CARRIERS ACROSS THE COUNTRY HAVE INFLUENCED PRICES BASED UPON HOW THE INDIVIDUAL CARRIER IMPLEMENTED THE SIX POINT PLAN AND OTHER HCFA METHODOLOGIES TO ALTER PRICES. SUCH "OTHER" METHODOLOGIES INCLUDE GAP FILLING, LOWEST CHARGE LEVELS, INHERENTLY REASONABLE AND LEASE/PURCHASE. WHEN THE RATES OF ONE CARRIER WHICH IMPLEMENTED ONE OR MORE OF THE METHODOLOGIES ARE COMPARED WITH THE RATES OF A CARRIER WHICH EMPLOYED DIFFERENT METHODOLOGIES, WIDE VARIATIONS IN PRICING WERE THE INEVITABLE RESULT. AGAIN, CONGRESS RECOGNIZED THESE VARIOUS CARRIER PRACTICES AND

DESIGNED THE SIX POINT PLAN TO CORRECT THIS PRACTICE WHICH WAS WIDESPREAD UNDER PRIOR LAW.

SOME REPORTED VARIATIONS MAY NOT BE ACTUAL VARIATIONS BUT INDEED MAY BE THE RESULT OF ERRONEOUS DATA OR VARIATIONS IN CODING BY CARRIERS FOR WHAT APPEAR TO BE THE SAME PRODUCT, BUT REALLY ARE NOT. CARRIER MISUNDERSTANDING IN HANDLING HME CODING ADDITIONS, DELETIONS AND CHANGES; LACK OF PURCHASE DATA; COMMINGLING OF RENTAL, NEW PURCHASE AND USED PURCHASE DATA; LACK OF ADEQUATE VOLUMES OF DATA FOR SOME HEM ITEMS; AND THE INABILITY TO TIE IN THE MULTITUDE OF DATA ELEMENTS, CHARGES, COMPARABILITY RATES AND INHERENTLY REASONABLE RATES ALL CONTRIBUTE ENORMOUSLY TO VARIATIONS IN PRICING. IN A RECENTLY RELEASED MEMORANDUM, HCFA IN FACT ADMITTED THAT INCONSISTENT CODING HAS CAUSED BROAD VARIATIONS IN FEE SCHEDULED AMOUNTS.

IN ENACTING THE SIX-POINT PLAN REFORM LEGISLATION IN 1987, CONGRESS ADOPTED LEGISLATION WHICH REDUCED HME REIMBURSEMENT BUT RECOGNIZED THAT THE COSTS OF PROVIDING HME SERVICES VARY BY GEOGRAPHIC AREA AND APPROPRIATELY ACCOUNTED FOR THIS FACT. LAST YEAR, CONGRESS RECOGNIZED THIS AS WELL WHEN IT REJECTED A PROPOSED NATIONAL CAP FOR HME. WE URGE THIS COMMITTEE TO ACT IN A LIKE MANNER THIS YEAR.

TO SUMMARIZE, THE COSTS OF PROVIDING HME ITEMS ARE NOT SIMPLY BASED UPON THE COST OF THE PRODUCT, BUT UPON THE COSTS OF PROVIDING

THE SERVICE IN LOCAL COMMUNITIES. AS WITH HOSPITALS, HOME HEALTH AGENCIES AND PHYSICIAN PAYMENTS, REIMBURSEMENT VARIATION IS NECESSARY TO ACCOUNT FOR LOCAL WAGE AND OTHER DIFFERENCES. THUS, THE MECHANISM TO ADDRESS SUCH COST VARIATIONS CREATED BY THE SIX POINT PLAN IS BOTH REASONABLE AND ENTIRELY APPROPRIATE.

B. MODIFY FEE SCHEDULE FOR HME RENTAL ITEMS

PROPOSAL:

THE ADMINISTRATION PROPOSAL RECALCULATES RENTAL FEE SCHEDULES BASED ON AVERAGE ALLOWED CHARGES RATHER THAN ON 1985-1986 SUBMITTED CHARGES, AND REDUCES RENTAL PAYMENT FROM 150 PERCENT TO 120 PERCENT OF THE PURCHASE PRICE.

RESPONSE:

THE CURRENT CAP FOR RENTAL ITEMS OF 150 PERCENT WAS ADOPTED BY CONGRESS IN OBRA '87 ONLY AFTER CAREFUL CONSIDERATION OF ALL PERTINENT HME INDUSTRY FACTS AND CIRCUMSTANCES. AFTER 15 MONTHS OF CONTINUOUS RENTAL, MEDICARE MAKES NO FURTHER RENTAL PAYMENTS ON BEHALF OF BENEFICIARIES. AFTER 21 MONTHS OF CONTINUOUS USAGE, SUPPLIERS MAY RECEIVE A SMALL SERVICE AND MAINTENANCE FEE WHICH CONTINUES SEMI-ANNUALLY. SUPPLIERS RECEIVE NO FURTHER RENTAL PAYMENTS AND ARE REQUIRED TO REPLACE EQUIPMENT EVEN IF THE ITEM IS LOST, STOLEN OR

ABUSED. SUPPLIER COSTS ARE "FRONT-END LOADED" AND, AS SUCH, THE SIX POINT PLAN CALCULATED A 15 MONTH REIMBURSEMENT MECHANISM TO RECAPTURE THESE EXPENSES ADEQUATELY. THE 150 PERCENT PROVISION RECOGNIZED THAT THERE ARE NON-REIMBURSABLE COSTS WHICH SUPPLIERS WILL INCUR AFTER THE 15 MONTH CAP IS REACHED.

CONGRESS RECOGNIZED THESE COSTS AND THE INDUSTRY RECOGNIZED AND ACCEPTED THE UNKNOWN FUTURE LIABILITY TO SERVE BENEFICIARIES' NEEDS FOR LONG TERM PERIODS OF MEDICAL NECESSITY. THE EXTENT OF THIS LIABILITY IS STILL UNKNOWN BY THE INDUSTRY, BUT IN SOME MARKETS, THE EQUIPMENT NOW AT CAPPED RENTAL IS GROWING RAPIDLY. WHAT WE DO KNOW IS THAT RETURNS ON ASSETS ARE DECLINING.

DEMOGRAPHICS SUGGEST THAT THE NEED FOR HME SERVICES WILL GROW. EXPERIENCE AND FINANCIAL RESULTS DOCUMENT THAT SUPPLIERS HAVE A SHORTAGE OF WORKING CAPITAL. WORKING CAPITAL REQUIREMENTS ARE EXTENSIVE; THE INDUSTRY MUST PURCHASE NEW EQUIPMENT AND FINANCE ACCOUNTS RECEIVABLE COLLECTIONS THAT AVERAGE 90 DAYS. ACCORDING TO DEFINITIVE INDUSTRY STUDIES BY PROFESSOR WILLIAM DROMS OF GEORGETOWN UNIVERSITY AND PROFESSOR RONALD STEPHENSON OF INDIANA UNIVERSITY, AVERAGE PROFITS AND RETURN ON INVESTMENT HAVE DECLINED BY 50 PERCENT IN THE LAST TWO TO SIX YEARS, RESPECTIVELY. THE STUDIES DOCUMENT THAT CURRENT INDUSTRY PROFITS ARE INSUFFICIENT TO FUND WORKING CAPITAL REQUIREMENTS AS BENEFICIARIES' NEEDS FOR SERVICES GROW.

BECAUSE OF REDUCED PER BENEFICIARY REVENUES, HIGHER LABOR COSTS

AND SLOW AND UNPREDICTABLE ACCOUNTS RECEIVABLES COLLECTIONS FOR MEDICARE SERVICES, THE HME INDUSTRY HAS A SEVERE WORKING CAPITAL PROBLEM. HME COMPANIES CANNOT GAIN ACCESS TO NEEDED CAPITAL FROM OUTSIDE RESOURCES TO PURCHASE NEW PRODUCTS FOR THE EXPANDING BENEFICIARY POPULATION.

THE ADMINISTRATION'S PROPOSAL IS UNSOUND HEALTH POLICY AND WOULD EXACERBATE THE ALREADY POOR FINANCIAL HEALTH OF THE HME INDUSTRY. AGAIN, THE ADMINISTRATION'S IDEAS ARE NOT NEW AND WERE REJECTED BY CONGRESS IN 1989. THEY DESERVE SIMILAR TREATMENT THIS YEAR.

C. REDUCE OXYGEN PAYMENTS BY 5 PERCENT

PROPOSAL:

OBRA '87 ESTABLISHED A FEE SCHEDULE FOR OXYGEN BASED ON 95 PERCENT OF THE LOCAL AVERAGE AMOUNT REIMBURSED BY MEDICARE IN 1986. THE ADMINISTRATION PROPOSES TO REDUCE MEDICARE PAYMENT AMOUNTS BY AN ADDITIONAL 5 PERCENT.

RESPONSE:

ALTHOUGH THE SIX POINT PLAN WAS DESIGNED TO ACHIEVE A 5 PERCENT REDUCTION IN OXYGEN EXPENDITURES, IT ACTUALLY PRODUCED UP TO 30 PERCENT REDUCTIONS ACROSS THE COUNTRY. HCFA USED DATA USED TO CALCULATE THE REIMBURSEMENT AMOUNTS FOR OXYGEN WHICH INCLUDED LOW-USE

(PRN) PATIENTS WHO WOULD NOT BE COVERED UNDER TODAY'S MORE STRINGENT OXYGEN COVERAGE RULES.

THE DANGEROUSLY LOW OXYGEN REIMBURSEMENT AMOUNTS ALREADY HAVE LIMITED BENEFICIARY ACCESS TO SPECIFIC SERVICES IN CERTAIN MARKETS. FOR EXAMPLE, NATIONAL HME COMPANIES HAVE CLOSED BRANCHES IN STATES WITH LOW REIMBURSEMENT AND DISCONTINUED SERVICE IN SOME RURAL COMMUNITIES. THE MAYO CLINIC HAS REPORTED IT CAN NO LONGER DISCHARGE OXYGEN AND VENTILATOR PATIENTS INTO PARTS OF THE MIDWEST BECAUSE PROVIDERS CAN NO LONGER AFFORD TO SERVE THESE PATIENTS.

THE HME INDUSTRY STRONGLY OPPOSES FURTHER REDUCTIONS IN OXYGEN REIMBURSEMENT WHICH WOULD HAVE AN ADVERSE EFFECT ON BENEFICIARY ACCESS IN THIS MANNER.

D. PROVIDE PRIOR AUTHORIZATION AUTHORITY TO CARRIER

PROPOSAL:

THE ADMINISTRATION PROPOSES TO EXTEND TO MEDICARE PART B CARRIERS THE AUTHORITY TO REQUIRE PRIOR AUTHORIZATION FOR CERTAIN MEDICAL SERVICES AND/OR EQUIPMENT.

RESPONSE:

CURRENTLY, HCFA REQUIRES MEDICARE CARRIERS TO IDENTIFY CLAIMS FOR

HME THAT SHOULD NOT BE PAID OR SHOULD BE PAID AT A LOWER LEVEL. THESE ACTIVITIES, PAYMENT OR PROGRAM SAFEGUARDS, MAY OCCUR PRIOR TO THE CARRIER DECISION TO PAY A CLAIM (I.E. PREPAYMENT) OR SUBSEQUENT TO THE CARRIER DECISION TO PAY A CLAIM (I.E. POSTPAYMENT).

PRIOR AUTHORIZATION IS EXPENSIVE TO ADMINISTER AND DELAYS REIMBURSEMENT ON LEGITIMATE CLAIMS. THEREFORE, REQUIRING PRIOR AUTHORIZATION ON ALL HME PAYMENT CLAIMS WOULD BE UNWIELDY, IMPRACTICABLE AND INEFFICIENT. PRIOR AUTHORIZATION WOULD COMPOUND AN ADMINISTRATIVE PROCESS THAT ALREADY OVERWHELMS PHYSICIANS, HOSPITALS AND ALL HME PROVIDERS. IN ADDITION, THE POTENTIAL SAVINGS TO THE PROGRAM ARE MINIMAL.

THE HME INDUSTRY WOULD ENDORSE THE SELECTIVE USE OF PRIOR AUTHORIZATION ON SPECIFIC ITEMS OF EQUIPMENT WHERE THERE IS EVIDENCE OF SUBSTANTIAL UNNECESSARY UTILIZATION. WHERE HCFA DETERMINES THAT REQUIRING A PHYSICIAN'S WRITTEN ORDER PRIOR TO DELIVERY IS INSUFFICIENT TO ADDRESS ALLEGED ABUSES, HCFA MIGHT BE AUTHORIZED TO REQUIRE THAT THE ITEM ALSO SHOULD BE SUBJECT TO THE CARRIER'S PRIOR APPROVAL BEFORE DELIVERING THE ITEM. THIS NEW SAFEGUARD SHOULD BE PRECEDED BY A NOTICE IN THE FEDERAL REGISTER, PROVIDING AN OPPORTUNITY FOR COMMENT. TO PROTECT BENEFICIARIES, CARRIERS WOULD BE REQUIRED TO GRANT OR DENY APPROVAL WITHIN 5 WORKING DAYS OR APPROVAL WOULD BE AUTOMATICALLY DEEMED.

E. ENTERAL NUTRITION FEE SCHEDULE

PROPOSAL:

THE ADMINISTRATION IS SEEKING AUTHORITY TO IMPOSE A FEE SCHEDULE ON ENTERAL NUTRIENTS AND SUPPLIES USED IN ENTERAL TUBE FEEDINGS, WHICH WOULD BE BASED ON WHOLESALE AND RETAIL PRICES OF CERTAIN PRODUCTS USED IN ORAL FEEDINGS. HCFA HAS PRESENTED THIS SAME PROPOSAL TO CONGRESS IN EACH OF THE PAST THREE YEARS, AND CONGRESS HAS REJECTED IT EACH TIME.

RESPONSE:

WE URGE CONGRESS AGAIN TO REJECT HCFA'S ATTEMPT TO USE WHOLESALE AND RETAIL PRICES OF ORALLY ADMINISTERED PRODUCTS TO DETERMINE REIMBURSEMENT FOR ENTERAL TUBE FEEDING, A SIGNIFICANTLY DIFFERENT MEDICAL PROCEDURE.

IN 1986, CONGRESS ADDRESSED THIS ISSUE IN GREAT DETAIL, AND ENACTED LEGISLATION MANDATING THE APPLICATION OF THE MEDICARE LOWEST CHARGE LEVEL METHODOLOGY TO DETERMINE MEDICARE PART B REIMBURSEMENT FOR ENTERAL NUTRITION. BY VIRTUALLY ALL ACCOUNTS, THE LOWEST CHARGE LEVEL METHODOLOGY AND THE INFLATION-INDEXED CHARGE LIMIT HAVE WORKED WELL TO CONTAIN MEDICARE EXPENDITURES AND TO ENSURE THE PROVISION OF ESSENTIAL CLINICAL SUPPORT SERVICES THAT SHOULD ACCOMPANY ENTERAL TUBE FEEDINGS.

HCFA'S PROPOSAL, HOWEVER, WOULD CREATE PERVERSE INCENTIVES AGAINST THE USE OF THESE SERVICES -- WHICH INCLUDE TRAINING OF THE PATIENT AND HIS OR HER FAMILY IN ENTERAL TUBE FEEDING, 24-HOUR EMERGENCY ASSISTANCE, AND EQUIPMENT MAINTENANCE AND REPAIR -- SINCE THE COSTS ASSOCIATED WITH SUCH SERVICES WOULD NOT BE ADEQUATELY REFLECTED IN HCFA'S FEE SCHEDULE. THE HME INDUSTRY OPPOSES HCFA'S PROPOSAL FOR AN ENTERAL NUTRITION FEE SCHEDULE.

F. COMPETITIVE BIDDING FOR HME

PROPOSAL:

THE FY 1991 BUDGET NOTES THE ADMINISTRATION'S HOPES TO CONDUCT HME COMPETITIVE BIDDING DEMONSTRATIONS IN FY 1991. THE ADMINISTRATION IS SEEKING "A MORE LONG-TERM SOLUTION TO THE ISSUE OF DETERMINING APPROPRIATE MEDICARE PAYMENT LEVELS FOR HME" AND BELIEVES COMPETITIVE BIDDING MAY PROVIDE THAT SOLUTION.

RESPONSE:

THE HME INDUSTRY OPPOSES COMPETITIVE BIDDING FOR THE HME INDUSTRY. THE ABILITY OF COMPETITIVE BIDDING TO REALIZE SAVINGS FOR MEDICARE, WHILE SAFEGUARDING QUALITY, DEPENDS CRITICALLY ON THE DESIGN, IMPLEMENTATION AND SUBSEQUENT ADMINISTRATION OF THE BIDDING SYSTEM ADOPTED.

WITH ANY COMPETITIVE BIDDING SYSTEM, THE FIRST ISSUE TO BE ADDRESSED MUST BE A DETERMINATION OF WHAT LEVEL OF SERVICE THE GOVERNMENT IS WILLING TO PAY FOR. OTHERWISE, THE GOVERNMENT SHOULD BE CONCERNED THAT THE HME SERVICE COMPONENT WILL DIMINISH OR DISAPPEAR. COMPETITIVE BIDDING IS KNOWN TO WORK POORLY FOR THE DEFENSE DEPARTMENT AND VA, PLACES WHERE IT IS ALREADY USED ON A LARGE SCALE SIMILAR TO WHAT MEDICARE WOULD REQUIRE.

DEFINING PRODUCT CATEGORIES, AREAS OF GEOGRAPHIC COVERAGE, AND BUNDLED SERVICES TO BE INCLUDED; CONVINCING SUPPLIERS TO TRUST INFORMATION PROVIDED BY HCFA AND ITS CARRIERS; AND DEALING WITH THE ENORMOUS COMPLEXITIES OF A NEW AND UNKNOWN SYSTEM FOR DOING BUSINESS, ABSENT THE INCENTIVES OF A "WINNER-TAKE-ALL" SYSTEM, OR OF SIMPLIFIED BILLING, (MEDICAL NECESSITY QUESTIONS WOULD PRESUMABLY STILL EXIST), WOULD VERY LIKELY RESULT IN A DISASTER OF ONE SORT OF ANOTHER. EITHER THE MEDICARE PROGRAM WOULD SPEND MORE TO IMPLEMENT AND ADMINISTER SUCH A PROGRAM THAN IT WOULD SAVE, OR, THE NUMBER OF SUPPLIERS AVAILABLE TO BID WOULD RAPIDLY SHRINK TO THE POINT WHERE THE SURVIVORS WOULD HAVE LITTLE COMPETITION OR THE HME BENEFIT WOULD ESSENTIALLY CEASE TO EXIST, DIRECTLY COUNTER TO OTHER FEDERAL POLICY INITIATIVES DESIGNED TO EXPEDITE DEINSTITUTIONALIZATION.

IT IS VERY HARD TO DESIGN AND ADMINISTER A COMPETITIVE BIDDING PROCESS SUCH AS DESCRIBED ABOVE WITHOUT DAMAGING THE MARKET. IF A WINNING BID GOES TO ONE PROVIDER, THIS WILL DRIVE MANY SMALL COMPANIES OUT OF BUSINESS AND THEN THE SOLE WINNER IN FUTURE YEARS WOULD

HAVE A CONSIDERABLY REDUCED LEVEL OF COMPETITION. IF MULTIPLE WINNING BIDS ARE APPROVED, THEN NO INCREMENTAL BENEFIT EXISTS FOR INCREASED VOLUME. THEREFORE, THERE IS NO POTENTIAL ADVANTAGE FOR A DEMONSTRATION PROJECT.

HCFA SEEMS TO BE LOOKING FOR PER UNIT PRICES TO SET THE BIDDING PROCESS. HOWEVER, MOST SUPPLIERS DO NOT HAVE THE HISTORICAL DATA NEEDED TO ACCURATELY SET THIS PER UNIT PRICE, AND THEREFORE THEIR BIDS WILL PROBABLY BE TOO HIGH OR TOO LOW. HCFA HAS VERY LITTLE KNOWLEDGE OF THE SERVICE COMPONENT FOR THE INDUSTRY. THAT NEEDS TO BE BUILT IN TO THIS BIDDING PROCESS. MUCH EDUCATION NEEDS TO BE DONE WITH INDIVIDUAL SUPPLIERS AND HCFA IN ORDER TO REALLY UNDERSTAND THE PRICE OF SERVICES AS OPPOSED TO THE MERE ACQUISITION COSTS OF THE EQUIPMENT.

COMPETITIVE BIDDING FOR CERTAIN SELECTED HME ITEMS HAS BEEN TRIED AND SUBSEQUENTLY ABANDONED IN A NUMBER OF STATES. THERE ARE ENORMOUS COMPLEXITIES INVOLVED IN DIVIDING THE ENTIRE NATION INTO MULTIPLE AND REASONABLE SERVICE AREAS. FEW SUPPLIERS PROVIDE ALL POSSIBLE HME SERVICES AND THEREFORE IT WOULD BE NECESSARY TO DEFINE DIFFERENT SERVICE AREAS FOR DIFFERENT KINDS OF EQUIPMENT. IT CURRENTLY TAKES ON AVERAGE 90 DAYS FOR HME SUPPLIERS TO GET PAID; AS A RESULT, IT IS HIGHLY UNLIKELY ANY COMPANY WOULD HAVE THE CAPITAL NECESSARY TO EXPAND INTO NEW SERVICES IN ORDER TO TAKE ON LARGE COMPETITIVELY BID CONTRACTS.

SIGNIFICANTLY, VA HOSPITALS HAVE EXPERIENCED DEFICIENCIES DOCUMENTED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS (JCAHO) DUE TO THE QUALITY OF HOME CARE PROVIDED BY VA CONTRACT WINNERS. MEDICARE WOULD HAVE TO EXPECT SIMILAR IF NOT GREATER PROBLEMS IN ACCESS AND QUALITY. THE VA, ONCE ACQUIRING A SIGNED CONTRACT IN CERTAIN STATES, HAS MONITORED THE PROVIDER FOR PROVISIONS OF SERVICES. THE VA HAS IDENTIFIED THEY HAVE NO AWARENESS OF HOME OXYGEN AND HME EQUIPMENT IN THE AREAS OF: QUALITY; APPROPRIATENESS OF EQUIPMENT; VARIOUS TYPES OF EQUIPMENT; SAFETY FEATURES OF EQUIPMENT; AND CURRENT PRICING OF EQUIPMENT. REVIEW OF SIGNED "LOW BID" CONTRACTS ACROSS THE SOUTHEAST AND SOUTHWEST VA SYSTEM REVEALED HIDDEN CHARGES. SIMILARLY, THE DISASTROUS RESULTS OF COMPETITIVE BIDDING UNDER THE DEPARTMENT OF DEFENSE ARE A MATTER OF PUBLIC RECORD.

IF CONGRESS MUST TRY THIS APPROACH, WE URGE THAT YOU CLOSELY SCRUTINIZE PRIOR MISTAKES, CONSULT CLOSELY WITH THE HME INDUSTRY, AND THOROUGHLY DEMONSTRATE THE CONCEPT IN A FEW AREAS FOR FOUR YEARS AND HAVE THE RESULTS EVALUATED THOROUGHLY BY INDEPENDENT OUTSIDE PARTIES. PATIENT CARE AND MEDICARE BENEFICIARY WELL-BEING ARE AT STAKE.

* * * * * * * * * * *

IN CONCLUSION, THE HME INDUSTRY STRONGLY OPPOSES THE ADMINISTRATION'S PROPOSED HME CUTS OF $250 TO $320 MILLION FOR FY 1991. THE INDUSTRY IS MORE THAN WILLING TO WORK WITH CONGRESS TO DEVELOP

ALTERNATIVE REVENUE SAVINGS MEASURES WHICH WILL PROVE LESS INTRUSIVE TO BENEFICIARIES AND THE HME INDUSTRY WHILE ALLOWING CONGRESS TO REACH ITS BUDGET TARGET. IN FACT, THE HME INDUSTRY ALREADY HAS MET WITH HEALTH SUBCOMMITTEE STAFF REGARDING A SERIES OF BUDGET SAVINGS OR BUDGET NEUTRAL PROPOSALS TO REFINE THE SIX POINT PLAN, INCLUDING: CREATING A PURCHASE OPTION; DEFINING CUSTOMIZED REHABILITATION EQUIPMENT; PRIOR AUTHORIZATION FOR CERTAIN HME ITEMS; REGIONAL CARRIERS; AND ACCESS TO BENEFICIARY IDENTIFICATION INFORMATION. PLEASE REFER TO ATTACHMENT A HERETO.

PROVIDERS OF HME PLAY A VITAL ROLE IN ALLOWING MANY OF OUR CITIZENS, WHO OTHERWISE MIGHT REQUIRE HOSPITAL OR NURSING HOME CARE, TO REMAIN AT HOME. THESE PROVIDERS RECOGNIZE THE NEED TO ESTABLISH STANDARDS FOR PAYMENT AND CONTROL UTILIZATION UNDER MEDICARE PART B. WE ARE COMMITTED TO WORKING WITH CONGRESS AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TO PREVENT FRAUDULENT AND ABUSIVE PRACTICES AND, DUE TO GROWING BUDGET DEFICITS, ARE PREPARED TO TAKE A PROPORTIONAL SHARE OF MEDICARE EXPENDITURE CUTS.

HOWEVER, WE URGE CONGRESS TO MAKE ANY CUTS IN HME REIMBURSEMENT IN A MANNER WHICH PRIORITIZES PATIENT CARE NEEDS AND IS CONSISTENT WITH THE FRAMEWORK CREATED BY THE HME REFORM LAW AS PASSED IN OBRA '87 AND ASSURES A CPI UPDATE IN FY 1991.

WE AS A NATION SHOULD BE ENCOURAGING HOME HEALTH CARE OPTIONS, NOT RULING THEM OUT. THIS IS TRUE NOT JUST FOR FISCAL REASONS -- IT IS LESS EXPENSIVE TO KEEP PEOPLE AT HOME THAN IT IS IN AN IN-PATIENT FACILITY -- BUT FOR QUALITY OF LIFE REASONS AS WELL. SURELY, IF PEOPLE CAN BE PROPERLY CARED FOR IN THE COMFORT OF THEIR FAMILIAR SURROUNDINGS, WE SHOULD BE ENCOURAGING CARE AT HOME.

THE HME INDUSTRY THANKS YOU FOR THIS OPPORTUNITY TO TESTIFY AND LOOKS FORWARD TO WORKING WITH CONGRESS TO FIND NEEDED SAVINGS WITHOUT DISRUPTING QUALITY HOME CARE.

ATTACHMENT A

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

Rehabilitation Equipment

Issue: (a) Definition of Customized Equipment

Section 6112 (d)(2) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, calls for HHS to:

> "by regulation specify criteria to be used by carriers in making determinations on a case-by-case basis as whether to classify power-driven wheelchairs as a customized item ... for purposes of reimbursement [under the Medicare Act]."

Custom rehabilitation equipment has to do with people who, by virtue of a disability or disease, have a continuing and substantial need for specialized equipment. This equipment must be custom ordered or modified through responsible providers who strive to meet the challenges posed by the functional deficits of the users. Since each individual has a unique set of characteristics associated with his/her disability, workable solutions to overcome the functional losses must be made on an individual basis. This results in a need for a custom designed and fitted product.

Thus far, HHS has yet to publish a Notice of Proposed Rulemaking defining customized equipment. HCFA is relying on minimal House Budget Committee language from the Conference Report of OBRA '87 as guidance and, as such, has improperly interpreted, and therefore inadequately reimbursed for, customized equipment.

Proposal: Congress should define customized equipment as follows:

Power-driven and other wheelchairs for beneficiaries with disabilities such as: spinal cord injury, severe head trauma, neuromuscular disease, amputees, multiple sclerosis, cerebral palsy, congenital deformities, stroke, polyarthritis, brain injuries, burns, polio and post-polio syndrome, peripheral

vascular diseases and disability secondary to diseases, should be considered customized whenever they have been:

1. measured, fitted or adapted in consideration of a patient's body size, level of disability, length of need, and intended use; and

2. has been assembled by the supplier or ordered through a manufacturer or manufacturers who make available custom features, modifications, and components that are intended for a specific patient's use in accordance with a physician's medical justification.

Some examples of equipment features that are available solely and exclusively in the construction of customized equipment include, but are not limited to:

Semi-reclining back for customized wheelchair
Full reclining back for customized wheelchair
Special height arms for wheelchair
Special back height for wheelchair
Special wheelchair seat height
Special wheelchair seat depth
Special wheelchair seat depth and/or width
Wheelchair attachment to convert any wheelchair to one-arm drive
Custom postural contral devices
Custom molded cushions, inserts
Lateral supports

Other modifications also may be added to a custom wheelchair.

Budget Impact: Budget neutral; simply clarifies those items which should be placed in the customized category.

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

Prior Approval for Customized Equipment

Issue: Customized rehabilitation equipment by its very nature must be special ordered, constructed and modified to fit the individualized needs of people with disabilities such as arthritis, polio, multiple sclerosis, muscular dystrophy and cerebral palsy. Because of the unique nature of customized items, they often are quite costly. Having suppliers produce and supply an item without assurance of payment places the supplier at great financial risk. Having carriers process claims for such customized items which are ultimately denied and appealed carries an unnecessarily high administrative cost burden to the Medicare program. Prior carrier approval for customized rehabilitation equipment would prevent this burden on both suppliers and carriers.

Proposal: Congress should require that HCFA authorize carriers to approve claims for customized rehabilitation equipment prior to production of the item. To protect the beneficiaries, carriers should be required to grant or deny prior approval within 5 working days or approval would be automatically deemed.

Budget Impact: Savings from deterring unnecessary utilization detected through prior approval. Administrative cost savings to the program by reducing high cost levels of claims reviews, reconsiderations, hearings and other appeals.

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

Purchase Option

Issue: There is a major flaw in the Capped Rental category of the Six Point Plan. The medical equipment supplier must replace items in the Capped Rental category at the supplier's own expense as long as the patient qualifies for that item. In cases of young disabled patients, this could be over fifty or sixty years. Initially this was not a problem because the Health Care Financing Administration (HCFA) provided a "purchase option" within the Capped Rental category. The option to purchase equipment which currently falls under the Capped Rental category should be at the discretion of the Medicare beneficiary. Unfortunately, HCFA was advised by their legal counsel to remove the purchase language due to "lack of congressional intent." The purchase option was then reluctantly removed by HCFA.

Proposal: Congress should require that HCFA promulgate a rule establishing the original purchase option language. The language contained in HCFA's transmittal instruction, which is as follows, should be adopted:

E. Capped Rental Items. -- For these items of DME, pay on a rental or purchase basis. For rental items, generally pay on a monthly rental basis not to exceed a period of continuous use of 15 months. However, where the beneficiary has purchased an item of equipment without prior rental, pay monthly installments equivalent to rental fee schedule amounts until the actual charge for purchase is reached, until 10 months have expired, or the medical necessity ends, whichever occurs first. If the purchase was preceded by a period of rental, reduce the 10-month limit by one month for every month of rental in excess of five. (Therefore, if a purchase occurs during a period of continuous use after 15 months of rentals have been paid, no payment may be made other than the reasonable and necessary charges for maintenance and servicing.)

Budget Impact: Proposal should be budget neutral and may even create savings since total payments would not exceed that which would have been paid had the equipment been continuously rented.

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

New Rental Period/Capped Rental Category

Issue: Capped Rental calls for a single 15 month rental period with unlimited, long-term maintenance and possibly replacement for all items of HME in this category. This particular requirement under the Six Point Plan does not account for the adverse economic impact upon suppliers in those few cases where a patient's need may continue for years.

Proposal: Congress should require HHS to develop guidelines for the "reasonable length of life" for all capped rental items. This period normally will be several years. Once the "reasonable life" of an item is reached (e.g. 2-4 years), the supplier could initiate another rental period with a new item of equipment. In developing these guidelines, HHS would be required to do so in consultation with the home medical equipment industry. Implementation January 1, 1993 for equipment rented in 1989 or thereafter.

Budget Impact: Budget neutral through December 31, 1992.

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

Changing Suppliers When Patient Moves or Original Supplier Ceases Operations

Issue: Under present law, a supplier is entitled to 15 months of rental payments for items of equipment provided to a Medicare beneficiary. Thereafter, the patient may keep the item as long as a medical need exists, but the supplier is not entitled to further rental payments. In addition, the supplier must repair and even replace the item totally for only a service fee paid every 6 months. The service fee may not exceed an amount equal to one month's rental.

Where the original supplier ceases operations or a patient moves outside the original supplier's service area, the receiving supplier may only receive any balance remaining of the 15 months rental (which may be zero) but still retains the full service and replacement obligations. This is unfair to both the receiving supplier and patients who may be unable to find a receiving supplier willing to incur the loss of serving them.

Proposal: Congress should require HCFA to commence a new 15 month rental period where the patient has moved beyond the original supplier's reasonable service area or the original supplier has ceased operations.

Budget Impact: Small but justifiable increases necessary to protect patient access to Medicare services.

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

Prior Approval/Specialty Carriers

Issue: Current law provides that if HCFA identifies a pattern of "abuse" with respect to a specific item of equipment, HCFA may require a supplier to have a written physician's order in hand before delivering that item to the patient. At present, HCFA has exercised this authority with respect to five items. The five items are: TENS, seatlifts, POVs, moist heating pads and certain decubitus ulcer items. This prior approval has reduced, but not eliminated, instances of alleged abuse.

Proposal: Congress should authorize HCFA to apply another safeguard at its discretion. Where the agency determines that requiring a physician's written order prior to delivery is insufficient to address alleged abuse, HCFA could also require that the item be subject to the carrier's prior approval before delivering the item, after publishing a notice in the Federal Register and providing an opportunity for the HME industry too comment. To protect patients, carriers would be required to grant or deny approval within 5 working days or approval would be automatically deemed.

HCFA also would be authorized to designate two or more specialty carriers to process all claims for items for which a physician's written order prior to delivery is required.

Budget Impact: Savings through deterring unnecessary utilization and further savings through reducing administrative costs through carrier consolidation.

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

Regional or Speciality HME Carriers

Issue: At present, Medicare HME claims are processed by over 50 carriers across the nation. This results in a lack of uniform program administration and ensures that no carrier has sufficient HME claims volume to warrant the time and resources necessary to develop true HME expertise. Current legislation authorizes -- but does not require -- HCFA to designate regional carriers to handle all HME claims for States within their region.

Proposal: Congress should require HCFA to: complete transition to regional or specialized carriers for HME claims by 1995, and consult with industry on carrier selection. Congress should authorize HCFA to consider non-insurance entities for claims processing and should require GAO to study and report to Congress on the transition to and implementation of regional or specialized carriers, including: A. Impact on supplier/carrier costs of claims administration; B. Lost claims and delays in reimbursement; C. Impact on beneficiary access; and D. Efficiency, timeliness and effectiveness of HCFA's carrier oversight.

Budget Impact: Savings due to increased carrier efficiency and uniform program administration.

HOME MEDICAL EQUIPMENT INDUSTRY
LEGISLATIVE PROPOSAL

Medical Specialists/Seatlifts

Issue: HCFA is considering eliminating coverage of seatlifts to achieve savings and eliminate alleged fraud and abuse. This approach is overly broad and would harm patients who legitimately benefit from the product.

Proposal: A better approach is for Congress to require HCFA to promulgate a rule providing that only certain physician specialists may prescribe seatlifts for Medicare reimbursement purposes. HCFA would have to solicit public input before exercising this authority. Examples of specialists HCFA might decide upon include orthopedists, neurologists, rheumatologists, gerontologists, and physiatrists.

Budget Impact: Would protect patients who genuinely need seatlifts while producing savings by deterring unnecessary utilization.

HIDA HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

health industry manufacturers association hima

NAMES National Association of Medical Equipment Suppliers

HOME CARE LEGISLATIVE PROPOSAL:

Expansion of Regional Pricing:

Issue:

Currently, under the Six Point Plan reimbursement system for durable medical equipment (HME), all fee schedules are local; each carrier establishes its own fee schedules for HME items according to the specific legislated methodology for each of the six categories of items. In 1991, the fee schedules for three of the six categories under the Six Point Plan: oxygen, prosthetics and orthotics, and rental cap items, will be calculated on a regional basis and must fall within an allowed national variance to reflect differences in local costs of labor, insurance, etc. Regionalization will be completed by January 1993.

Fee schedules for items in two additional categories under the Six Point Plan; inexpensive and routinely purchased category, and frequent and substantial servicing category, do not currently become regional fee schedules. The sixth category: customized items is not-paid on a fee schedule basis and therefore does not require regional phase in.

Proposal:

This proposal would phase in regional fee schedules within an allowed national variance for the inexpensive and routinely purchased, and the frequent and substantial servicing categories.

Budget Impact:

Savings because the wide variances in fee schedule amounts would be limited by the national floors and ceilings.

HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

health industry manufacturers association hima

NAMES National Association of Medical Equipment Suppliers

HOME CARE LEGISLATIVE PROPOSAL:

Home Oxygen Retesting

Issue: Because of "sicker and quicker," there are many patients now recovering from hospital treatment at home. Some of these patients, recuperating at home, are short term oxygen users. Certain Medicare beneficiaries who initially qualify for coverage of oxygen therapy improve (particularly if they have recently had an acute care episode) and no longer need oxygen therapy. On the other hand, many beneficiaries will require long term oxygen therapy. The implementation of DRG payments for hospitals has resulted in a change in the types of patients receiving oxygen at home.

Current Medicare requirements for oxygen coverage are very specific and identify three coverage categories for a beneficiary based on results of a hospital, physician office, or independent laboratory analysis of arterial blood gas or oximetry tests. The three coverage categories are:

1. the patient's arterial PO2 is 56 mm Hg or below or arterial blood saturation is 88 percent or below;
2. the patient's arterial PO2 is 56 - 59 mm Hg or the arterial blood saturation is 89 percent and there is evidence of a. dependent edema suggesting congestive heart failure, b. "P" pulmonale on EKG, or c. erythrocythemia with a hematocrit greater than 56 percent; and
3. the PO2 levels is 60 mm Hg or above or arterial blood oxygen saturation at or above 90 percent, need compelling medical justification.

The prescribing physician determines medical necessity and duration of need for oxygen. Following the physician's prescription, the HME supplier then provides the oxygen equipment and services. So long as the physician recertifies beneficiary need at least every 12 months, laboratory retesting is not required.

Proposal: Patients that initially qualify for oxygen coverage with an arterial blood gas level of 56 mm Hg or above or with an arterial blood saturation of 89 percent should be required to have a new laboratory test to confirm continued long term use between two and seven months of beginning therapy.

If a patient meets the medical necessity requirements for oxygen upon the retesting, the patient shall be covered, as under current regulations, for continuous long term use, provided the physician recertifies need every 12 months.

Patients with certain diagnoses (e.g., cancer, certain lung diseases, etc.) will need long term continuous oxygen and therefore do not need retesting.

All patients qualifying for oxygen therapy before the effective date of this provision shall be grandfathered under the previous rules, and not be subject to retesting.

In implementing this provision, HCFA shall consult with industry.

Budget Impact: Savings because fewer beneficiaries would qualify for long term oxygen therapy.

HIDA HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

health industry manufacturers association hima

NAMES National Association of Medical Equipment Suppliers

HOME CARE LEGISLATIVE PROPOSAL:

"Prompt Pay" For "Unclean" Claims

Issue:

Currently, Medicare's prompt payment requirements (42 U.S.C. 1395(u)(c)) require carriers to process 95% of all durable medical equipment (HME) clean claims within 24 days (for claims submitted on or after October 1, 1989). If a carrier fails to meet this standard, Medicare must pay interest on the claim, for the 25th day to the date of payment.

The law defines a "clean claim" as "a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment, that prevents timely payment from being made."

Once a carrier deems a claim "unclean", there is no financial or other incentive to develop or pay that claim within a reasonable period of time. Carrier prepayment or postpayment safeguard activities often result in a claim becoming "unclean" as well. While these safeguard activities aim to prevent improper utilization, most claims subject to prepayment activities are not downgraded or denied, but are ultimately paid.

Proposal:

Carriers are required to deny or pay HME "unclean" claims within 45 days of receipt of the payment claim. Thus all claims must be adjudicated within 45 days: clean claims within 24 days, unclean claims within 45 days.

Carriers are further required to notify HME suppliers in writing within 48 hours of the time that they determine the claim is "unclean" and specify the reasons for that determination so that the supplier may submit additional information or notify the beneficiary and physician that the claim may not be paid.

Budget Impact:

Budget neutral because original prompt pay law assumed carriers would process all claims within 45 days.

S. 1562

On August 4, 1990, Senator Bob Graham (D-FL) introduced a bill (S. 1562) to expedite payment of Part B claims by increasing interest on late payments and to broaden the category of claims eligible for interest payments. We strongly support this bill and urge you to act positively on it.

HOME CARE LEGISLATIVE PROPOSAL

HME Supplier Verification of Select Beneficiary Identification and Insurance Information at Time of Service

Issue:

Home medical equipment supplier electronic access to verify beneficiary identification and insurance information would benefit HCFA, beneficiaries and suppliers because it would make more efficient claims processing, reducing unnecessary administrative costs. HME suppliers should be able to verify select information at the time a Medicare beneficiary, pursuant to a physician's prescription, requests service from the HME company. To facilitate an answer as to whether the beneficiary may be denied Medicare coverage for non-medical necessity reasons prior to submitting an assigned or non-assigned claim the HME company needs to be able to verify: beneficiary name; health insurance claim number; beneficiary current residence (skilled nursing facility, hospital); insurance coverage (Medicare, Medicaid, Health Maintenance Organization, Medicare as secondary payor); duplicate service; and deductible status. The system would be similar to a Mastercard or Visa verification system where information provided by the beneficiary and the prescribing physician to the supplier is entered and transmitted electronically to Medicare, whereupon the information receives a Yes/No response.

This prior authorization step for technical details would reduce carrier claim development (particularly MSP) costs, and claims that carriers receive would contain fewer non-medical necessity errors. HCFA would benefit also by having an electronic data system in place to track supplier usage, and would easily be able to audit for abuses.

The Privacy Act, 5 U.S.C. 552a(b) permits disclosure of beneficiary information to any third party with the written consent of the beneficiary to whom the record pertains. Suppliers would obtain both verbal and written authorization from the beneficiary (as part of the assignment of benefits process) to verify information, and would submit to the carrier a copy of that authorization.

Proposal:

The Secretary shall, by January 1992, provide a system for home medical equipment suppliers to electronically verify selected beneficiary identification and insurance information at time of service during normal business hours. The Secretary is authorized to charge a reasonable user fee for such access, and may require suppliers to meet the following criteria to be eligible:

- obtain appropriate state business license
- be in compliance with DOT, FDA, OSHA and other federal or state requirements
- agree to an audit of beneficiaries' records
- have a patient bill of rights for beneficiary at time of delivery
- agree to file assigned and non-assigned claims on behalf of the beneficiary

A carrier cannot deem "unclean" or deny a claim based upon information verified from this file.

Budget Impact:

Savings because user fee, plus reduced outlays from prior screenings.

HOME CARE LEGISLATIVE PROPOSAL

Beneficiary Home Medical Equipment Upgrade

ISSUE: Medicare beneficiaries may be denied access to certain types of home medical equipment (HME) that they specifically request or that their physicians prescribe, on either a rental or purchase basis.

A majority of HME suppliers accept "assignment" under Medicare, i.e., they agree to accept the Medicare-approved charge as the total payment and may not charge the beneficiary amounts beyond the annual deductible and 20 percent co-insurance.

When a beneficiary, pursuant to a physician's prescription, wants to order an upgraded version of the standard wheelchair (e.g., extra high back seat cushion for additional support), a supplier accepting assignment is paid only for the standard wheelchair approved by Medicare. Even if the beneficiary is willing to pay the differential cost associated with the upgrade, a supplier accepting assignment is limited to either providing the beneficiary with the standard wheelchair or providing the upgraded version at no extra charge. In the end, Medicare beneficiaries usually receive HME that meets Medicare's standards, but not their own needs, or the physicians' preference.

Currently, a beneficiary has the freedom to choose whatever equipment he or she wants if the supplier does not accept assignment. If a claim is not assigned, a beneficiary may receive reimbursement for the Medicare allowed amount, i.e., the lesser of the supplier's charge or the Medicare fee schedule amount, and be responsible to the supplier for the full supplier charge. Thus, this proposal would make available to a beneficiary the same options whether the claim is assigned or not assigned.

PROPOSAL: The law should be modified to allow beneficiaries the option of applying the Medicare-approved charge amount, on an assigned basis, towards the total rental or purchase cost of an upgraded version of the Medicare-approved equipment, and paying for the costs associated with the upgrade. The Medicare deductible and co-insurance amounts would remain unchanged.

Changes in the law should incorporate safeguard provisions to protect the beneficiary and ensure appropriate use to the upgrade option. First, when offering an upgrade, the supplier should be required to offer and make available the standard piece of equipment. Second, when a beneficiary executes the assignment of benefits form, a statement should be signed indicating that he or she is exercising a voluntary and informed option to upgrade. Third, the upgrade statement should include an itemized list of the total charge components and the beneficiary's additional liability.

BUDGET IMPACT: Budget neutral.

ANALYSIS OF THE IMPACT OF REIMBURSEMENT CHANGES ON THE HOME MEDICAL EQUIPMENT INDUSTRY

Over the past few years, every segment of the health care industry has experienced changes in the methods used by third-party payers to reimburse for services provided, most of which have been intended to slow the rate of growth in payments to these providers. Changes made legislatively are generally well known; however, many changes affecting the industry have been implemented using instructions to claims payers or by regulation. Cumulatively, these changes have had a significant impact on the health care industry.

The home medical equipment (HME) industry has been particularly affected by these legislative and regulatory changes (see Appendix A). Significant policy changes that have had a substantial impact on reimbursement to the HME industry include:

- **OBRA '87** -- "Six Point Plan" established a new fee schedule for HME to begin January 1, 1989. The Six Point Plan was designed to produce savings and establish a uniform national reimbursement policy that allows for some regional variation.

- **OBRA '89** -- established several modifications to the "Six Point Plan," many of which result in significant reductions in payment for certain items.

In addition to these major legislative changes, it is less well recognized that numerous carrier transmittals modified the rules used by carriers to make payments to HME suppliers. These changes resulted in freezes in payment amounts, limits on payment for particular types of equipment, and requirements for extensive paperwork to justify the medical necessity of prescribed items. Congressional policy makers may be unaware of the cumulative impact of these legislative and administrative changes. In particular, data presented in this report document that HCFA's implementation of OBRA '87 has produced actual savings that exceed those estimated by CBO at the time of passage.

Most recently, the President's Fiscal Year 1991 budget proposes significant additional changes in the methods used to compute payments to HME providers. Specifically, the

budget proposal would foreclose any regional variation and establish a national cap on all fee schedules for HME, prosthetics and orthotics and oxygen, in addition to making further payment reductions. Any consideration of the President's proposals should take into account the data presented here regarding the estimated actual savings from the Six Point Plan and assess the impact of these prior changes on access to and quality of care provided to Medicare beneficiaries in the home.

This study is designed to analyze the impact of each of these changes on payments to HME suppliers. Data from the Health Care Financing Administration (HCFA) were used to compare payments in fiscal years (FYs) 1989 through 1993 under current policy to payments which would have been made had no changes occurred after FY 1987. In addition, we estimated the impact of the President's FY 1991 proposed budget on payments for home medical equipment through FY 1995. A review of the data shows that increased demand for HME services driven by demographic changes results in an increase in total HME outlays over time. Average reimbursement on a per item basis between 1987 and 1989 decreased as a result of the Six Point Plan. Projected increases depend upon assumptions used in the model that rates are inflated by the CPI. In the past few years, however, the HME industry has not received any payment amount increases due to budgetary constraints.

The following sections describe the data and methods used for the analysis and detail our findings.

I. METHODOLOGY

Medicare Part B data were used to develop a model projecting payments for home medical equipment over a period from 1989 to 1993 (and to 1995 for the President's budget). The Part B data include information on the number of submitted claims, number of allowed

claims, submitted charges, and allowed charges. Reimbursement data are provided by locality and for each specific type of equipment. Equipment type is identified by a code which can be either a national standard (HCPCS) code or a local carrier code. Data were used for calendar years 1986 and 1987.

From this data file we selected a sample comprising 90 percent of submitted charges for HME. The file was edited to correct any identified errors.[1] Local carrier procedure codes were included, and, to the extent possible, were recoded to the corresponding HCPCS code. In addition, all pricing modifiers were grouped into four categories: used, purchased, rented, and other. These distinctions were maintained because the model calculates payment amounts differently for each category.

The payment model was then developed for five types of HME:

- inexpensive/routinely purchased items (e.g., crutches, canes)
- items requiring frequent maintenance (e.g., ventilators, IPPB machines)
- capped rental items (e.g., hospital beds, wheelchairs)
- orthotics and prosthetics (e.g., ostomy supplies, lower limb prostheses)
- oxygen.

These five types of HME are based on the Medicare HCPCS codes and HCFA definitions.

The next section describes methods used to generate baseline payment amounts. The second section describes the methodology used in modeling the impact of OBRA '87 and OBRA '89 legislation, followed by a section describing the steps in modeling the impact of the President's FY 1991 proposed budget plan.

---

[1]For example, the Florida carrier data showed an average actual charge and average allowed charge for purchase items that were significantly lower than the average charges for these items for other carriers. Data were corrected by adjusting the submitted and allowed frequencies to produce average charges that were comparable to the other carriers.

A. Baseline Projections

Baseline projections of payments for HME were developed to estimate payment to HME suppliers in the absence of any legislative or regulatory change after passage of OBRA '87. This baseline was developed using calendar year 1987 data inflated each year by the annual percent increase in the Congressional Budget Office (CBO) estimates of growth in HME outlays. The percent increases used to produce the baseline estimates are shown in Table 1. The CBO estimate of payment increases incorporates assumptions regarding inflation as well as expected increases in utilization of HME products. Increases in utilization result from: 1) an increase in the Medicare eligible population and 2) a change in patterns of care which might influence use of HME (i.e, changes in practice patterns that have occurred due to the Medicare Prospective Payment System). In order to estimate payments beyond the base year, assumptions regarding changes in utilization are necessary. These assumptions regarding HME utilization were developed by subtracting the impact of inflation from CBO estimates of payment increases. The residual is due to estimated changes in utilization (see Table 1). The following sections describe the steps taken in determining the costs associated with each type of HME.

B. OBRA '87 and OBRA '89

Legislative changes made in 1987 and 1988 resulted in major changes in the methods used to calculate reimbursement for HME. Specifically the "Six Point Plan" made substantial reductions in reimbursement and created a payment system which phased-in a fee schedule that allows for regional variations limited by national parameters. This policy was designed to

TABLE 1

PROJECTED INCREASES IN MEDICARE HME OUTLAYS, INFLATION FACTORS, AND UTILIZATION

	Percent Increase in Medicare HME Outlays	HME Payment Inflation Assumptions[a]	Assumed HME Utilization Increase[b]
1987/88	6.67%	1.70%	4.97%
1988/89	6.25%	0.00%	6.25%
1989/90	5.88%	0.00%	5.88%
1990/91	15.79%	0.00%[c]	12.19%[d]
1991/92	13.64%	4.15%	9.49%
1992/93	12.00%	4.30%	7.70%
1993/94	10.71%	4.30%	6.41%
1994/95	12.90%	4.30%	8.60%

[a] HME payment inflation assumptions for 1987/88 through 1990/91 are the actual HME update factors that were applied to HME payment amounts for those years. This reflects payment freezes for three of these fiscal year periods. Assumptions for 1991/92 through 1994/95 are based on Congressional Budget Office projections that were made in March, 1990.

[b] Assumed utilization increases were derived by subtracting the percent increase in inflation for HME included on this table from the assumed percent increases in Medicare HME outlays included in Table 1.

[c] According to CBO estimates, a 3.6 percent HME update factor was assumed for 1990/91. This factor was not applied to the payment amounts in the model because this increase has not occurred in 1990.

[d] CBO estimates of baseline payment amounts are higher during fiscal year 1990-91 due to a provision requiring an acceleration in Part B payments during this period.

SOURCE: Adapted from Congressional Budget Office and General Accounting Office baseline estimates used for HME in 1987, 1989, and 1990.

reduce the local and state variation in payments for HME. Under the Six Point Plan, fee schedules are developed for various types of HME and reported by HCPCS. Methods for calculating the payments for each category of HME are discussed below.

1. Inexpensive/Routinely Purchased Items

According to the OBRA '87 legislation, data for the period June 1986 to June 1987 were to be used in calculating payments for inexpensive or routinely purchased items. Average payments calculated from this base year period were to be inflated by one-half of the CPI for calendar year 1987. Data for this time period, however, were not available because of the lack of "date of service" information on the Part B claims files. Instead, calendar year data for 1987 were used, without inclusion of the half year CPI adjustment.

In order to estimate payments for this type of HME, the average actual charge and the average allowed charge at the locality level were calculated. The payment amount is equal to the lower of these two values, and from 1991 to 1993, was increased by the CPI. Under OBRA 1989, seat-lift chairs and transcutaneous electrical nerve stimulators (TENS) received an 11.25 percent decrease in payment amounts for 1990 to 1993 (i.e., 15 percent for 3/4 of the year because the law was effective April 1, 1990).

2. Items Requiring Frequent Maintenance

Under the Six Point Plan, items requiring frequent maintenance can only be rented. Payment amounts for this equipment were estimated using the same methods described above. For those claims that were not rentals in the 1987 data, the frequency was added to the rental frequency to obtain a total claims frequency; however, the rental price was calculated using only rental dollars and rental frequencies.

3. Capped Rentals

The payment amount for capped rental items was calculated as the lower of the average actual charge for rentals in 1986 or ten percent of the average actual charge for purchase in 1986 at the locality level. This amount was constrained by an upper bound of 115 percent of the prevailing fee for each locality and a lower bound of 85 percent of the same prevailing fee in 1987. Items in the BMAD data that were other than rented were converted into rental items by assuming that each single purchase claim would result in an average of three monthly rental claims. This assumption was developed based upon data available from one carrier and the rental experience of one large HME supplier.[2]

Under the Six Point Plan, starting in 1991, a phase-in of regional payment amounts is scheduled to begin for capped rentals, prosthetics and orthotics and oxygen. In 1991, the payment amount is 75 percent of the local payment amount and 25 percent of the weighted average regional amount. In 1992, the respective percentages are 50 percent (local) and 50 percent (regional). Finally, in 1993, the payment amount is 100 percent of the regional amount. In each year, 1991 through 1993, the payment amount is further constrained by a "national" amount that is the simple average of the carrier service area amounts. The upper and lower bounds for capped rental items are 125 percent and 85 percent of the "national" amount, respectively. At this time, the estimates do not include a claims volume adjustment

---

[2]Rental data available showed that the average rental period for capped rental items ranged between six to eight months, depending on the item under consideration. However, due to the rent/purchase guidelines that were in effect, approximately 80 percent to 90 percent of these items had been rented four to six months prior to purchase of the item. Therefore, a purchase frequency was converted to three rental frequencies in the modeling of the capped rental savings estimates. Note that the model results are very sensitive to this assumption. For example, in 1989, the savings estimates for the capped rental category range from $87.0 million to -$24.3 million using a two month and four month purchase-to-rental conversion factor, respectively.

to account for a 15 month cap for rentals because of the lack of data on beneficiary service use.

4. Prosthetics and Orthotics

Under the Six Point Plan, prosthetics and orthotics can only be purchased. Items in the 1987 data that were other than purchased were added to the frequency for purchased items to obtain a total claims frequency; however, the purchase price was calculated using only dollars and frequencies for purchase claims. The payment amount was calculated as the lower of the average actual charge or the average allowed charge.

5. Oxygen

The final type of HME modeled was oxygen. It follows the same regional phase-in scheme as described above except that in 1991 and 1992 the final payment amount is constrained by an upper bound of 130 percent of the "national" average and a lower bound of 80 percent. In 1993, the upper bound is 125 percent and the lower bound is 85 percent. The local price was determined by taking the lower of the average actual charge or the average allowed charge for rentals in 1986. The payment amounts equal 95 percent of this calculated amount increased by the CPI for the six-month period of June through December 1987. Prior to calculating the payment amounts, all oxygen items were grouped into two types of oxygen systems, portable or stationary. The data are limited in that they lack utilization data by oxygen flow rates; therefore, we assumed that all oxygen claims were for flow rates falling between 1 and 4 liters/minute. This assumption is consistent with reported experience.

C. FY 1991 Budget

The five types of HME modeled under the Six Point Plan were used in estimating the impact of the President's FY 1991 Budget Proposal. Although the specifics of this proposal are not available, we estimated the impact of moving to a national median cap for the years 1991 through 1995. The other components of the proposal contained in the savings estimates include:

- Changing the basis for the fee schedule for capped rental items to average allowed charges, not submitted charges, making this fee schedule consistent with the other categories of HME.
- Reducing oxygen payment amounts an additional five percent.

Under this proposal, beginning in 1991, all items of HME are limited to 100 percent of the national median. Items that fall below the national median are eligible for an inflation update. If the updated amount exceeds the median, it is adjusted downward to the median value. In subsequent years, the process is repeated with a median calculated from the prior year's values in order to move to a national price.

Further changes were made for calculation of payments for capped rental HME. Payments were previously calculated using the lower of the average actual charge for rentals in 1986, or ten percent of the average actual purchase price in 1986. The proposed budget uses the average allowed charge in 1986 rather than the average actual (submitted) charge in 1986. The charge is again limited to an upper bound of 115 percent of the 1987 prevailing fee in the locality or 85 percent of the same prevailing fee.

The final change reflected in the FY 1991 Budget model was a five percent reduction in oxygen payments, for both portable and stationary. Other changes, such as the fee schedule for enteral products and the limit of rental payments to 120 rather than 150 percent

of the recognized purchase price, were not modeled because of the lack of sufficient data on the Medicare Part B file.

II. RESULTS

The results of our analysis are shown in Tables 2 and 3. Table 2 shows that baseline payment estimates would have increased from $1.6 billion in 1989 to $2.4 billion in 1993 or an average annual increase of 12 percent. Estimates of payment under the Six Point Plan increase from $1.4 billion in 1989 to $2.2 billion in 1993. Savings from the Six Point Plan, therefore are estimated to be $162 million in 1989, increasing to $228 million in 1993.

As shown in Table 2, savings from the Six Point Plan estimated by our model are substantially greater than the estimates of expected savings made by the Congressional Budget Office at the time of passage of this law. This difference is significant and one that Congress and Administration policymakers should consider in evaluating the President's FY 1991 proposals. Overall, savings estimates were positive for all HME categories (see Appendix B). Aggregate outlays for inexpensive and routinely purchased items in 1990 increased, however, because items previously included in the capped rental category (e.g., power-operated vehicles) were relocated to this category. Estimated savings were greatest for oxygen, averaging 22 percent of estimated outlays for oxygen each year.

Total estimated savings from the President's FY 1991 proposal are shown in Table 3. As shown, the plan proposed by the Administration would generate substantial budgetary savings in addition to those actually imposed by the Six Point Plan. In fact, we estimate that by 1995, savings resulting from this proposal will be 38 percent of the estimated baseline. Our estimates of savings from the proposed budget are from 26 percent to 72 percent greater than those estimated by the CBO. All types of HME produce savings, with oxygen

TABLE 2

OBRA 1987 AND OBRA 1989 TOTAL ESTIMATED SAVINGS UNDER SIX POINT PLAN (in millions $)

	Base	Six Point Plan	Savings	CBO Estimates of Savings Under Six-Point Plan
1989	$1,564.1	$1,402.6	$161.5	$60.0
1990	1,656.1	1,490.1	166.0	80.0
1991	1,917.6	1,729.4	188.2	125.0
1992	2,179.1	1,971.8	207.3	145.0
1993	2,440.6	2,212.8	227.8	160.0

SOURCE: Lewin/ICF estimates.

TABLE 3

PRESIDENT'S FY 1991 PROPOSED PLAN TOTAL ESTIMATED SAVINGS
(in millions $)

	Base	President's Proposed Plan	Savings	CBO Estimates of Savings Under The Proposed Plan
1991	$1,917.6	$1,385.9	$531.7	$310.0
1992	2,179.1	1,510.6	668.5	530.0
1993	2,440.6	1,628.4	812.2	595.0
1994	2,702.0	1,736.6	965.4	670.0
1995	3,050.6	1,891.6	1,159.0	750.0

SOURCE: Lewin/ICF estimates.

comprising more than half of the savings in each year of the projection. The majority of these savings result from imposition of the national cap at 100 percent of the median price. This cap causes a drastic reduction in several localities' recognized payment amounts in the first year of implementation, preventing a smooth transition to national rates.

In addition to examining the impact of the Six Point Plan on aggregate outlays, the impact on payment amounts was analyzed. As shown in Table 4, average payment amounts from 1987 to 1989 have declined for all HME categories except inexpensive and routinely purchased items (average payment amounts increased approximately 6 percent for this latter category). During this period, average payments declined for capped rentals (29 percent), stationary oxygen (18 percent), portable oxygen (6 percent), and items requiring frequent servicing (5 percent); average payment amounts for prosthetics and orthotics have remained roughly the same. By 1993, average payment amounts for three of the categories that show decreasing average payment amounts from 1987 to 1989 (i.e., items requiring frequent servicing, prosthetics and orthotics, and portable oxygen) are slightly higher than 1987 amounts.

A separate analysis of four HME products was conducted to determine the impact of the regionalization component of the Six Point Plan on payments. The four products considered include:

- portable oxygen (rented),
- stationary oxygen (rented),
- hospital bed (rented),
- lower limb prosthesis (purchased).

This analysis was developed using Medicare Part B data and incorporates local procedure codes, where used. Payments were calculated by state for the years 1987, 1989, 1991, 1992, and 1993.

TABLE 4

**AVERAGE PAYMENT AMOUNT
BY SIX POINT PLAN CATEGORY
FOR YEARS 1987, 1989 - 1993[a]**

Category	1987	1989	1990	1991	1992	1993
Inexpensive/Routinely Purchased	$95.41	$101.38	$100.37	$100.37	$104.54	$109.03
Frequent Servicing	70.57	66.90	66.90	66.90	69.67	72.67
Capped Rental	99.14	70.57	71.04	71.86	74.51	77.43
Prosthetics and Orthotics	6.92	6.90	6.90	7.12	7.51	7.83
Stationary Oxygen	223.09	183.85	183.85	190.11	197.35	205.84
Portable Oxygen	68.90	64.55	64.55	64.56	67.28	70.25

**PERCENT CHANGE FOR AVERAGE PAYMENT AMOUNTS
FOR ALL ITEMS BY SIX POINT PLAN CATEGORY, 1987-1989**

Category	1987	1989	Percent Change
Inexpensive/Routinely Purchased	$95.41	$101.38	6.26%[b]
Frequent Servicing	70.57	66.90	-5.20%
Capped Rental	99.14	70.57	-28.82%
Prosthetics and Orthotics	6.92	6.90	-0.29%
Stationary Oxygen	223.09	183.85	-17.59%
Portable Oxygen	68.90	64.55	-6.31%

[a] Average payment amounts for 1991 through 1993 assume a CPI adjustment to each year's payments as indicated on Table 1.

[b] An increase in inexpensive and routinely purchased items occurred due to the recategorization of certain products from the capped rental category.

SOURCE: Lewin/ICF estimates.

The results show that payment amount variation for these HME products under the Six Point Plan and the President's FY 1991 budget is significantly reduced due to the phase-in of regional fee schedules in 1991, producing further savings. Therefore, by 1993, payment variations across states have been substantially reduced. This is evidenced by declining standard deviations for oxygen, hospital beds, and lower limb prostheses products which are subject to regional phase-in. (See Appendix C for detailed results.)

III. CONCLUSIONS

Home medical equipment companies have experienced many changes which have had a substantial impact on both the level of payment for the services they provide and the methods used to calculate these payments. The Six Point Plan, while one of the most significant legislative changes, is not the only change that has affected this industry. The Six Point Plan created major changes in the methods used to calculate reimbursement and produced substantial savings which exceed those predicted by CBO at the time of passage. Other changes have frozen or further reduced payment levels for particular services.

Payments to all Part B Medicare providers, including home medical equipment companies, traditionally have exhibited wide regional variation. The Six Point Plan was designed to eliminate some of this variation by phasing-in regional payment rates within allowed national limits. This phase-in will not be complete until 1993; however, when complete, much of the current observed geographic variation will be eliminated. As discussed above, data on payments for particular products under the Six Point Plan shows that variation in payment amounts is reduced for those products subject to regional fee schedules.

The President's Fiscal Year 1991 Budget proposes to drastically reduce payments to home medical equipment suppliers by capping payments at the national median level, and in 1991, reducing outlays for oxygen 40 percent, capped rentals 21 percent, prosthetics and orthotics 18 percent, items requiring frequent maintenance 25 percent, and inexpensive and routinely purchased items 19 percent. While the President's proposed plan would clearly eliminate variation in payment amounts, it does not recognize the importance of local and regional variations in the cost of providing the services associated with home medical equipment. Such variation is caused by local factors, most importantly labor, which influence the cost of home medical equipment.[3]

Access to home care has been important in improving the efficiency of the health care system. Because of the availability of home medical equipment, Medicare beneficiaries can now be cared for at home, where care is frequently far less expensive than in the hospital or a nursing home. This analysis has shown that legislative and regulatory changes and carrier rules have had a substantial impact upon this industry over the past several years. Further change might jeopardize the industry's ability to continue to provide services to the elderly.

---

[3]For a complete discussion of this issue, see Lewin/ICF, The Medical Equipment Industry: An Examination of the Industry's Expense Structure, July 26, 1990.

APPENDIX A

HME LEGISLATION, REGULATIONS, CARRIER INSTRUCTIONS

1985

February 1985 — Implementation of the rent/purchase program which enabled the Medicare carrier to make the decision on whether payments for HME should be made on a rental or purchase basis.

October 1985 — HCFA instructs carriers to implement new oxygen coverage rules. In general, Medicare coverage of home oxygen and oxygen equipment will be considered reasonable and necessary only for patients with significant hypoxemia who meet certain medical documentation, laboratory evidence, and health conditions. The medical documentation consists of a short written statement by the attending physician indicating that other forms of treatment have been tried, have not been sufficiently successful, and oxygen therapy is still required. Laboratory evidence accompanying initial claims for oxygen therapy must include the results of a blood gas study that has been ordered and evaluated by the prescribing physician. Finally, only patients with certain health conditions may receive home oxygen therapy (e.g., patients with severe lung disease or with hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy).

1986

March 1986 — HCFA instructs carriers to take steps to ensure that seat lift chairs purchased or rented are medically necessary and meet Medicare coverage guidelines. As a result of this advisement, several carriers mandated completion of a certification of medical necessity (CMN) by the prescribing physician for all certifications and recertifications of seat lift chairs purchased or rented after April 1, 1986.

1987

March 1987 — Medicare Transmittal No. 1180 implements final regulations on "special reasonable charge limits," published in the Federal Register (8/11/86), that established the circumstances in which a carrier may depart from the reasonable charge method in setting an allowable price, the "inherent reasonableness" factors to be used in setting the price, and the required procedures for supplier notification. It also adds a new section on oxygen concentrator pricing; carriers must carefully consider the application of the inherent reasonableness criteria to the rental and purchase of oxygen concentrators.

APPENDIX A (continued)

HME LEGISLATION, REGULATIONS, CARRIER INSTRUCTIONS

	Medicare Transmittal No. 195 deletes the requirement that a physician's prescription specify the patient's oxygen concentration level and deletes the requirement that clinical improvement in the patient's condition be documented to justify reimbursement for portable oxygen. It also provides that a physician may specify the type of oxygen delivery system to be used (i.e., gas, liquid, concentrator), and if the type is specified, the medical reasons for selecting that system over alternative systems must be specified. If the physician does not specify, the carrier determines the appropriate payment based on the least costly type of oxygen delivery system that will serve the patient's needs. This transmittal also stipulates that a HME supplier is no longer considered a qualified provider or supplier of laboratory services for purposes of home oxygen guidelines in order to eliminate conflict of interest that may occur if HME suppliers were permitted to document the medical need for oxygen services they also provide.
April 1987	Final Notice in the Federal Register (4/20/87) that stipulates items subject to lowest charge levels. HCFA savings estimates due to this notice are $10 million in 1987 and 1988 and $20 million in 1989, 1990, and 1991 -- total of $80 million.
1988	
OBRA 1987	Section 4062 establishes a one-year freeze on charge limitations.
	New payment rules for HME ("Six Point Plan") to begin January 1, 1989.
July 1988	HCFA sends to carriers instructions on data base preparation for calculating new HME fee schedules. By August 1, 1988, carriers are to submit data to HCFA needed to identify national lists of "inexpensive equipment" (purchase price less than $150) and "routinely purchased equipment" (purchased 75 percent of the time).
October 1988	HCFA distributes to carriers final instructions for HME by HCPCS codes and by reimbursement category for calculation of fee schedules under the "Six Point Plan."
November 1988	Medicare Transmittal No. 1279 instructs carriers on implementation of HME fee schedules due to be in place for items and services provided on or after January 1, 1989.

APPENDIX A (continued)

HME LEGISLATION, REGULATIONS, CARRIER INSTRUCTIONS

December 1988	Carriers instructed by HCFA's Bureau of Program Operations (BPO) to release fee schedule to suppliers and to respond to all requests for data used in calculating the fee schedule.
1989	
January 1989	HCFA issues delay for at least 60 days in new fee schedule for oxygen due to errors and inconsistencies in payment rates across carriers.
February 1989	New draft instructions sent to carriers for the calculation of home oxygen fee schedules. In calculating the monthly payment amount, carriers were instructed to exclude the following: equipment rental claims where there are no contents in the same month, contents claims where there is no equipment rental in the same month, all purchase claims, and claims for accessories and supplies when there is no equipment rental in the same month. HCFA directs carriers to begin collecting data that will be used to establish a national fee schedule, effective July 1, 1989, of maintenance and service payments for HME in the capped-rental category.
June 1989	HCFA issues a directive that home oxygen certificates of medical necessity (CMN) must be completed only by the attending physician who signs the form or by an office assistant in that physician's employ. If evidence of medical necessity is not provided within 45 days of claim receipt by the carrier, payment may be reduced or denied. This directive is effective July 1, 1989.
August 1989	HCFA decides against a national consensus payment level for maintenance and service fees, payable at 6-month intervals on rental cap HME that is in continuous use for 22 months or more. Instead, carriers will develop their own schedules of maintenance and service fees.
December 1989	HCFA instructs carriers to immediately recognize purchase claims for power driven wheelchairs, to relocate five other HME items from the rental cap reimbursement category to the "inexpensive and other routinely purchased" category and to add parenteral infusion pumps to the HME rental cap category.

APPENDIX A (continued)

HME LEGISLATION, REGULATIONS, CARRIER INSTRUCTIONS

OBRA '89	Payment amounts for seatlift chairs and TENS (transcutaneous electrical nerve stimulators) furnished on or after April 1, 1990 are reduced by 15 percent. Range of amounts recognized as the purchase price for HME is narrowed for 1991 from "may not exceed 130 percent, and may not be lower than 80 percent" of the average of the purchase prices recognized for all the carrier service areas in that year to "may not exceed 125 percent, and may not be lower than 85 percent..." After 1991, the law reads, "may not exceed 120 percent, and may not be lower than 90 percent...". Establishes a one year freeze on payment amount increases.

APPENDIX B

ESTIMATES OF THE IMPACT OF THE SIX POINT PLAN

TABLE B-1

OBRA 1987 AND OBRA 1989
TOTAL ESTIMATED SAVINGS UNDER SIX POINT PLAN
(in millions $)

	Base	Six Point Plan	Savings	CBO Estimates of Savings Under Six-Point Plan
1989	1,564.1	1,402.6	161.5	60.0
1990	1,656.1	1,490.1	166.0	80.0
1991	1,917.6	1,729.4	188.2	125.0
1992	2,179.1	1,971.8	207.3	145.0
1993	2,440.6	2,212.8	227.8	160.0

SOURCE: Lewin/ICF estimates.

TABLE B-2

OBRA 1987 AND OBRA 1989
ESTIMATED SAVINGS UNDER SIX POINT PLAN:
INEXPENSIVE AND ROUTINELY PURCHASED ITEMS
(in millions $)

	Base	Six Point Plan	Savings
1989	$240.7	$235.1	$5.3
1990	254.9	260.6	-5.7
1991	295.1	292.4	2.7
1992	335.4	333.4	2.0
1993	375.6	374.6	1.0

SOURCE: Lewin/ICF estimates.

TABLE B-3

OBRA 1987 AND OBRA 1989
ESTIMATED SAVINGS UNDER SIX POINT PLAN:
ITEMS REQUIRING FREQUENT MAINTENANCE
(in millions $)

	Base	Six Point Plan	Savings
1989	$70.7	$65.0	$5.7
1990	74.9	68.8	6.1
1991	86.7	77.2	9.5
1992	98.5	88.1	10.4
1993	110.3	98.9	11.4

SOURCE: Lewin/ICF estimates.

TABLE B-4

OBRA 1987 AND OBRA 1989
ESTIMATED SAVINGS UNDER SIX POINT PLAN:
ORTHOTICS AND PROSTHETICS
(in millions $)

	Base	Six Point Plan	Savings
1989	$217.7	$213.4	$4.3
1990	230.5	226.0	4.5
1991	266.9	261.7	5.2
1992	303.3	302.4	0.9
1993	339.6	339.7	-0.1

SOURCE: Lewin/ICF estimates.

TABLE B-5

OBRA 1987 AND OBRA 1989
ESTIMATED SAVINGS UNDER SIX POINT PLAN:
CAPPED RENTAL ITEMS
(in millions $)

	Base	Six Point Plan	Savings
1989	$446.5	$415.2	$31.3
1990	472.8	432.9	39.9
1991	547.4	502.1	45.3
1992	622.1	570.0	52.1
1993	696.7	638.0	58.7

SOURCE: Lewin/ICF estimates.

TABLE B-6

OBRA 1987 AND OBRA 1989
ESTIMATED SAVINGS UNDER SIX POINT PLAN:
OXYGEN
(in millions $)

	Base	Six Point Plan	Savings
1989	$588.5	$473.9	$114.6
1990	623.1	501.7	121.4
1991	721.5	596.0	125.5
1992	819.9	677.8	142.1
1993	918.3	761.6	156.7

SOURCE: Lewin/ICF estimates.

APPENDIX C

REGIONAL HME ANALYSIS

A separate analysis of four HME products was conducted to determine the impact of the Six Point Plan and the President's FY 1991 budget on payments. The four products considered include:

- portable oxygen (rented),
- stationary oxygen (rented),
- hospital bed (rented),
- lower limb prosthesis (purchased).

This analysis was developed using Medicare Part B data and incorporates local procedure codes, where used. Payments were calculated by state for the years 1987, 1989, 1991, 1992, and 1993.

The results show that payment amount variation for these HME products under the Six Point Plan and the President's FY 1991 budget is significantly reduced due to the phase-in of regional fee schedules, producing further savings.

Therefore, by 1993, payment variations across states have been substantially reduced. This is evidenced by declining standard deviations for oxygen, hospital beds, and lower limb prostheses, all products which are subject to regional phase-in.

Detailed results are presented in the attached tables.

STATISTICS FOR SIX POINT PLAN AND PRESIDENT'S PLAN
FOR ALL STATES FOR PORTABLE OXYGEN - RENTED

	SIX POINT PLAN					PRESIDENT'S PLAN				
STAT	1987	1989	1991	1992	1993	1987	1989	1991	1992	1993
MEAN	62.77	59.00	60.79	64.02	67.94	62.77	59.00	48.59	46.87	46.02
STD	20.95	17.28	10.54	9.08	8.54	20.95	17.28	9.77	7.17	5.44
MAX	117.21	113.78	80.28	80.40	83.85	117.21	113.78	58.26	52.81	49.99
MIN	29.06	27.71	49.40	54.67	57.02	29.06	27.71	25.01	26.05	27.17
RANGE	88.15	86.07	30.88	25.73	26.83	88.15	86.07	33.25	26.76	22.82
MEDIAN	61.56	60.17	60.59	62.04	67.88	61.56	60.17	52.63	50.40	49.10

STATISTICS FOR SIX POINT PLAN AND PRESIDENT'S PLAN
FOR ALL STATES FOR STATIONARY OXYGEN - RENTED

	SIX POINT PLAN					PRESIDENT'S PLAN				
STAT	1987	1989	1991	1992	1993	1987	1989	1991	1992	1993
MEAN	200.34	167.74	182.41	190.64	202.03	200.34	167.74	133.64	122.02	113.25
STD	59.98	64.43	32.55	28.30	28.66	59.98	64.43	42.80	33.59	26.99
MAX	303.36	273.73	234.71	235.05	245.15	303.36	273.73	165.92	143.07	128.73
MIN	49.34	41.33	144.44	159.83	166.70	49.34	41.33	37.30	38.84	40.51
RANGE	254.02	232.40	90.27	75.21	78.45	254.02	232.40	128.63	104.23	88.22
MEDIAN	206.90	182.20	181.08	189.72	200.24	206.90	182.20	157.67	143.07	128.73

STATISTICS FOR SIX POINT PLAN AND PRESIDENT'S PLAN
FOR ALL STATES FOR HOSPITAL BEDS - RENTED

	SIX POINT PLAN					PRESIDENT'S PLAN				
STAT	1987	1989	1991	1992	1993	1987	1989	1991	1992	1993
MEAN	75.87	85.41	87.20	92.45	99.00	75.87	75.74	70.59	68.56	67.91
STD	22.34	29.58	11.47	9.82	9.33	22.34	22.46	14.22	10.65	8.87
MAX	150.49	194.39	108.30	108.28	112.93	150.49	148.87	84.93	76.22	73.09
MIN	31.92	2.17	73.64	81.21	84.70	31.92	31.92	31.92	33.24	34.67
RANGE	118.58	192.21	34.65	27.07	28.23	118.58	116.95	53.02	42.98	38.42
MEDIAN	73.06	83.65	83.69	90.84	102.08	73.06	73.06	73.06	73.61	73.09

STATISTICS FOR SIX POINT PLAN AND PRESIDENT'S PLAN
FOR ALL STATES FOR LOWER LIMB PROSTHESIS - PURCHASED

	SIX POINT PLAN					PRESIDENT'S PLAN				
STAT	1987	1989	1991	1992	1993	1987	1989	1991	1992	1993
MEAN	2502.78	2501.07	2571.37	2694.42	2805.64	2502.78	2501.07	2375.94	2319.67	2284.56
STD	518.70	518.66	314.87	257.16	234.00	518.70	518.66	386.01	306.48	261.96
MAX	3571.42	3571.42	3227.87	3242.46	3381.88	3571.42	3571.42	2697.95	2492.15	2395.51
MIN	1230.23	1230.23	2205.22	2431.84	2536.41	1230.23	1230.23	1222.38	1224.22	1245.51
RANGE	2341.19	2341.19	1022.65	810.61	845.47	2341.19	2341.19	1475.57	1267.93	1150.00
MEDIAN	2553.71	2553.71	2567.31	2663.61	2818.02	2553.71	2553.71	2523.42	2469.98	2395.51

Mr. WAXMAN. Thank you, Mr. Jones.

Let me ask you some questions. In discussing the wide variations in the payments by Medicare for similar items and supplies around the country, you make the point that the lack of uniformity in the coding of these services from carrier to carrier makes comparisons difficult and unreliable.

Could you elaborate on this problem and any efforts to eliminate these disparities?

Mr. JONES. The wide variation in pricing is due to three reasons. One is commingling of old data that goes back to 1986, and the mixture of one product versus another in a combination of HCPC's, which may not be the same. That is a problem acknowledged by the Health Care Financing Administration as they proceed to roll forward and prepare regional fee rates for the January 1 time period.

In addition, all carriers were given different time frames for implementing the number of legislative initiatives over the past years. To the extent they implement those in varying degrees, it produced wide variations.

Mr. Chairman, I would also say we have that modeled for the committee, and we can provide you verification of key products.

Mr. WAXMAN. One of the proposals you recommend would require Medicare patients receiving oxygen therapy to be retested for their continuing need for service. Can you tell us what the average cost of such blood tests would be, and what effect they would have on any savings to Medicare that would result from more appropriate use of oxygen therapy?

Mr. JONES. It is my best understanding that the blood gas test currently has a fee screen of approximately $35. We are endorsing secondary testing in oxygen, based upon two factors: The Inspector General has reported that in an analysis of five States, that he believes that there was over $30 billion of expenditures for oxygen service that was unnecessary.

In addition, a leading group of pulmonologists is now indicating, due to the DRG, some patients are being discharged on oxygen for an acute period of time that may not need it on a chronic basis. We believe if those patients are tested, the reality will be oxygen patients, who deserve the therapy on a long-term basis, will receive it, and those that do not require it on a long-term basis will be eliminated.

Mr. WAXMAN. You have also recommended Medicare carriers be authorized to require prior approval for specific home equipment items where there is evidence of substantial overutilization. Could you give us some examples of what products in your experience are prescribed excessively or for patients who receive no benefit from them?

Mr. JONES. The industry has, to some extent, been blamed for the growth of a product that has been advertised on national television. To a large extent, members of our trade association certainly do not participate in the sale of this type of product, nor do they advertise on late night television, although the product is, in fact, described as a durable medical equipment product.

If the Health Care Financing Administration believes that there is abuse in products such as transcutaneous electric nerve stimula-

tors, seat lift chairs, or three-wheel scooters, then our industry supports prior approval for those products where there is great concern about the medical need prior to the beneficiary actually receiving the product.

Mr. WAXMAN. I want to thank you very much for your presentation to us, and we look forward to working with you.

Mr. JONES. Thank you, Mr. Chairman. Mr. Chairman, may I ask the Lewin report be added to the official record?

Mr. WAXMAN. Without objection, we will receive it for the record. [See p. 213.]

Mr. JONES. Thank you very much.

Mr. WAXMAN. That concludes our hearing for today, and we stand adjourned.

[Whereupon, at 12:35 p.m., the hearing was adjourned.]

[The following statements were submitted for the record:]

AMERICAN ACADEMY OF NURSE PRACTITIONERS

This document is submitted in behalf of the American Academy of Nurse Practitioners to address methods for reducing Medicare costs while continuing to meet the medical needs of the elderly. Nurse practitioners can play a major role in meeting those needs in a cost effective manner without sacrificing the quality of the service provided.

Men and women over the age of 65 are the major consumers of medical care in this country. By the year 2000, the percentage of the population most in need of health care ie the poor and the elderly will have increased substantially. It is estimated that the elderly population alone will comprise thirteen percent of the total population (1). Current estimates identify the poverty rates among the elderly at twelve percent, those age 85 and over having double the rate (21%) as those age 65-74 (2). Another seventeen percent have been estimated to be among the near poor (3). The rates among minority populations are reported to be the highest. The need for increased expenditures for medical care for the elderly can only increase in the years to come.

Nurses are the major health care providers for elderly populations in both acute and ambulatory care settings. In a recent report of the Office of Technology Administration (4), nurse practitioners were reported to be particularly well suited to care for the elderly due to their dual preparation in nursing and medicine. This preparation enables nurse practitioners to manage the chronic and acute medical conditions which commonly affect the elderly. In addition, they are prepared to assist the elderly in attaining and maintaining a higher quality of life by guiding and

supporting their health promoting activities of both an emotional and physical nature.

In the national survey of nurse practitioners conducted by the American Academy of Nurse Practitioners, over 75% of the adult and family nurse practitioners, 97% of the geriatric nurse practitioners and 70% of the women's health nurse practitioners provide primary care services to people over the age of 65. The majority of the patients seen by these nurse practitioners have annual incomes of less than $16,000(5). Yet these people cannot use their Medicare insurance to pay for the primary care services of the nurse practitioner except in very limited circumstances, ie long term care facilities and rural health clinics. Elderly people need to be able to utilize nurse practitioners to meet their primary care needs, particularly in rural and urban areas unable to retain physicians.

The quality and cost effectiveness of the care provided by nurse practitioners has been documented in over 400 studies. It is well known that nurse practitioners rate high in consumer satisfaction. This combination of factors suggests that the Medicare Program should be utilizing these providers extensively to provide medical care to the elderly. The inclusion of nurse practitioners as primary care providers in the Medicare system would contribute to the reduction of expenses incurred in the provision of health care to this population. Record (6) and Denton (7) in their investigations calculate savings of $300,000,000 to $1,000,000,000 annually if nurse practitioners were used to provide the services they are qualified to provide.

Nurse practitioners provide cost savings without sacrificing quality of care in a number of ways:

They are less costly to prepare. According to the Office of Technology Assessment six nurse practitioners can be prepared for every physician who is prepared to provide primary care(8).

Cost saving measured through the reduction of patient hospital days among patients in practice settings using nurse practitioners have been demonstrated in studies such as those conducted by Runyan et al(9).

The emphasis on prevention, health promotion and early detection of medical problems by nurse practitioners in primary care settings contributes to the reduction of more expensive medical problems rising later from unmet medical needs, another cost savings to the patient and the program.

According to the national survey conducted by the Academy, mean charges for primary care services provided by nurse practitioners are less than physician charges for the same services.

Nurse practitioners don't need to be forced into caring for the elderly, nor do they need large financial incentives to get them to continue to practice in "undesirable locations" whether it is rural America or the inner city. They do need, however, to have the opportunity to practice in a manner fitting their advanced education and practice and to be provided with an equal opportunity to receive direct reimbursement for their services. Based on the plethora of available data, nurse practitioners are viable and valuable health care providers that if properly utilized can

provide a cost savings to the Medicare Program without sacrificing quality of care and patient satisfaction.

The American Academy of Nurse Practitioners wishes to thank the Committee on Energy and Commerce for its concern for the health care of the elderly in America. We too are concerned about the ability of this segment of the population to access quality cost effective care both now and in the future. We would like to help and we appreciate the opportunities you can provide to allow us to do that. We urges you to include nurse practitioners as primary care providers in the Medicare system in order to insure that access, quality of care and cost effectiveness Of health care reaches America's elderly population as you desire.

References

1. Physician Payment Review Commission (1987) Medicare Physician Payment: An Agenda for Reform. Washington D.C.

2. ibid.

3. ibid.

4. Office of Technology Assessment, US Congress (1986) Nurse Practitioners, Physician Assistants and Certified Nurse Midwives: A Policy Analysis. Washington D.C.: U.S. Government Printing Office.

5. Towers, J. (1989) Preliminary Report of the National Survey of the American Academy of Nurse Practitioners. Journal of the American Academy of Nurse Practitioners. Vol 1,(1) pp 30-32 and Unpublished Final Report, Summer 1990.

6. Record, J.C. (ed)(1979) Provider Requirements, Cost Savings and the New Health Practitioner in Primary Care: National Estimate for 1990. Contract 231-77-0077 Washington D.C.: Department of Health Education and Welfare, 1979.

7.Denton, F.T. (1983) Potential Savings from the Adoption of Nurse Practitioner Technology in the Canadian Health Care System. Socio-Economic Plan Sci 17 (4): 199-209.

8. Office of Technology Assessment, US Congress (1986) Nurse Practitioners, Physician Assistants and Certified Nurse Midwives: A Policy Analysis. Washington D.C. US Government Printing Office.

9. Runyan, J.W. (1975) The Memphis Chronic Disease Program: Comparisons in Outcomes the Nurse's Extended Role. Journal of the American Medical Association. Vol 231(3) pp264-267

Statement of the American Association of Bioanalysts

Summary

The American Association of Bioanalysts (AAB) is particularly pleased to present comments to the House Energy and Commerce Health Subcommittee regarding the Administration's Fiscal Year 1991 budget proposals. AAB is comprised of directors, owners, managers, and supervisors of independent community clinical laboratories from across the country. Our members are directly affected by the decisions you will make on the FY 1991 budget.

This year, the President has proposed additional reductions in Medicare reimbursement for laboratory services. We firmly oppose these cuts. The laboratory industry has already absorbed a disproportionate share of Medicare reductions. AAB also opposes the Administration's plan to implement a competitive bidding demonstration project in FY 1991 and we urge reinstatement of the Congressional moratorium on this project. We believe the proposals advanced by the Administration will not produce any significant savings in the short run, and are likely to increase program costs in the long run.

Medicare Reductions

The laboratory industry has borne an inordinate share of the Medicare reductions in recent years. During the last six years, the fee schedule has been reduced eight times and frozen twice. The net result is that for some tests the reimbursement rate is well below fifty percent of the 1984 level, even without adjusting for inflation. While other segments of the health care industry continue to receive increases at double the rate of inflation, there are few, if any, groups which have been forced to absorb reimbursement reductions.

The President's Budget recommends the following modifications in laboratory reimbursement for FY 1991:

-- a reduction in the national cap on the fee schedule from 93 percent to 90 percent;

-- a reduction in the cap for profile and "standardized" tests to 80 percent of the national median; and

-- a full CPI increase for those tests not controlled by the national caps.

These modifications are projected to produce Medicare savings of $60 million in FY 1991. However, these "savings" are illusory. The current budget process produces proposals which nominally satisfy the Gramm-Rudman requirement for the current year but do little to actually lower federal expenditures. In order to produce real savings, Congress must address the issue of laboratory overutilization which is due in large part to self-referral in physician office laboratories.

Further Reductions in the Reimbursement Rates will Harm Community Laboratories.

In recent years, Congress has repeatedly reduced the national cap, which is now set at 93 percent of the national median. These reductions were originally justified as a method of eliminating unwarranted disparities in regional fee schedules. Congress and the Administration have progressively ratcheted the cap down so that almost all tests are now reimbursed at a level which is equal to or below the lowest regional rates in effect in 1984, thereby eliminating regional payment differences.

Further reductions in the fee schedule can only be justified by information demonstrating that the entire fee schedule is too high. Congress directed the GAO to analyze laboratory payments and provide a report to Congress by no later than January 1, 1990. This report was intended to provide Congress with the information necessary to make informed policy decisions regarding laboratory reimbursement. However, this report has yet to be filed. We believe that until this report is available it would be inappropriate to proceed with further Medicare reductions.

Community-based laboratories are facing significant new expenses for CLIA '88 certificates, increased proficiency testing requirements, new OSHA standards, hazardous and medical waste disposal, and higher Social Security taxes. In addition, a shortage of qualified clinical laboratory personnel has developed over the past four years and is becoming increasingly severe, causing salaries to skyrocket.

We fear that a continuation of reductions in the Medicare laboratory fee schedule will affect access to quality laboratory services for many Medicare beneficiaries, particularly those serviced by the community hospital and independent clinical laboratory.

Competitive Bidding

AAB is also firmly opposed to a competitive bidding demonstration project. In the past, Congress has prohibited the Department from implementing this project because of quality concerns. We understand that the Administration is once again considering the same model which led to earlier moratoriums. Competitive bidding schemes have several major problems.

First, this purchasing mechanism places an inordinate emphasis on cost. All competitive bidding models provide substantial preferences to the lowest bidders. Some models are exclusive. Others permit multiple winners. However, in every case, incentives are created for labs to sacrifice quality in order to become one of the lowest bidders.

Second, it is unrealistic to assume that the reforms contained in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) will protect the consumer from quality concerns generated by the financial pressures of competitive bidding. On May 21, 1990 the Department of Health and Human Services published the proposed rules implementing CLIA '88. These rules would exempt 17 tests from all forms of government regulation. This means that for these tests there will no longer be any proficiency testing, no personnel standards, and no quality control requirements.

Third, competitive bidding will lead to a further concentration of the industry which will ultimately drive up, rather than reduce, prices. We expect that in the early years, the large corporate laboratories will use their financial resources to underbid the Medicare contracts in order to eliminate competition from small community based labs. These losses will be made up after a few giant corporations have monopolized the market.

Even on a demonstration basis, competitive bidding would radically and irrevocably alter the structure of the laboratory industry in the demonstration areas. This is simply not the appropriate time to engage in such a risky experiment.

Real Reductions in Laboratory Expenditures

AAB recommends that Congress focus its attention on modifications in the reimbursement and regulation of the laboratory industry which will produce real, rather than illusory, savings. Previous efforts to control lab costs have focused on the fee schedule and have ignored utilization. As a consequence, the estimated budget savings related to these fee schedule cuts are more than offset by substantial increases in the volume of testing.

The best method for controlling laboratory expenditures is to limit the ability of physicians to profit by ordering laboratory tests. Enactment of the Stark Bill, which bars physicians from maintaining ownership interests in independent laboratories was a step in the right direction. However, the Stark bill did not address the primary setting in which physicians profit from lab testing, the doctor's office. According to the OIG, physician office testing accounted for 50 percent of all laboratory services reimbursed by Part B of the Medicare program in 1987.

The same financial incentives which cause physician-owners to overutilize lab tests in joint venture/limited partnership labs, are present and even stronger in the doctor's office. These financial incentives must be eliminated if Medicare is serious about deficit reduction and controlling lab payments. We are prepared to work with the Committee in developing initiatives to address this issue.

Finally, AAB believes that uniform regulation of all laboratory settings will reduce overutilization. As long as physician offices or other testing sites are not required to comply with the same quality control and personnel standards as independent labs, there will be adverse consequences, not only on quality, but also on Medicare expenditures. In this regard, we are particularly concerned about the May 21 proposed CLIA regulations which exempt over seventeen tests from any form of regulation, and an additional eleven tests from personnel requirements. In effect, this decision would permit many physician offices to operate without any federal regulation and will create incentives for expanding the volume of testing in this setting.

We believe that effective utilization controls combined with firm and uniform regulation of all laboratory settings will produce significant real savings for the Medicare program.

STATEMENT OF THE AMERICAN CLINICAL LABORATORY ASSOCIATION

A. Introduction

The American Clinical Laboratory Association (ACLA), an organization of federally regulated independent clinical laboratories, appreciates this opportunity to comment on the Administration's Fiscal Year 1991 budget proposals for Medicare reimbursement of clinical laboratories. This Committee faces the difficult task of determining where and how Medicare cuts should be made, and ACLA wishes to offer its assistance this year as it has in past years.

ACLA must emphasize, however, that independent laboratories have suffered substantial reimbursement reductions in each of the past six years. In the laboratory industry, as in health care generally, quality requires the expenditure of substantial funds. Ensuring that beneficiaries continue to have adequate access to high-quality care costs money. At a time when laboratories face increasing costs stemming from changes in the health care environment, the need to meet the highest quality standards and new regulatory requirements, the basic fact is that laboratories cannot continue to absorb significant cuts in reimbursement without some effect on either quality or access to services.

The Administration's FY'91 budget package proposes wide-ranging changes to Medicare's reimbursement of laboratory testing that threaten to seriously undermine the industry's ability to provide high-quality testing services. ACLA has reviewed the proposal and has identified several parts of it which the Association will not oppose. However, other portions of the proposal could make it impossible for many laboratories to survive and could impair quality and access.

In this statement, ACLA first reviews the impact of recent laboratory reimbursement reductions. Against this background, ACLA then discusses its position on the Administration's FY'91 laboratory proposals. Finally, the Association presents its own proposal, which it urges the Committee to consider as an alternative to the package advanced by the Administration.

B. The Current State of Laboratory Reimbursement

Since 1984, when Congress instituted the current laboratory fee schedule methodology, laboratories have suffered eight cuts in payment rates and two freezes in reimbursement levels. ACLA learned recently of an independent consulting firm survey of Medicare reimbursement rates for laboratories in the state of Oregon. This survey, which was not undertaken for ACLA or any of its members, found that for nine commonly ordered tests, 1990 Medicare reimbursement was only 45 percent of what it was in 1984, before the fee schedules went into effect. Moreover, when the effects of inflation or Gramm-Rudman-Hollings sequestration are included, this reduction is even greater.

The results of this survey are not unusual. ACLA members did a similar survey of laboratory reimbursement in 12 other states based on 15 commonly ordered tests. The numbers set out below show the 1990 Medicare reimbursement as a percentage of what it was in 1984 before the institution of the fee schedules.

California	62%	Minnesota	54%
Connecticut	66%	New Jersey	66%
Delaware	64%	New York	68%
Illinois	62%	Ohio	51%
Kansas	62%	Texas	61%
Maine	66%	Virginia	63%
Michigan	65%	West Virginia	62%

In sum, in no state surveyed by ACLA were laboratories being paid more than 68 percent of what they were being paid in 1984 before the implementation of the fee schedules.[1/]

Obviously, few industries can suffer such cutbacks without some effect. However, the impact of these rollbacks is even greater since during this same period, most items, and certainly most health care commodities and services, have increased in cost. For example, between 1984 and 1989, the Consumer Price Index (CPI) rose by over 19 percent,[2/] while the index for all medical services rose by approximately 40 percent.[3/] Indeed, between 1988 and 1989 alone, the cost of outpatient services alone rose by over 10 percent.[4/]

Moreover, laboratories have been faced with a number of specific increases in expenses over the last several years. The emergence of AIDS, for example, has caused laboratories to spend growing amounts on safety precautions to protect laboratory workers. New regulations to be issued by the Occupational Safety and Health Administration that require laboratories to take additional precautions to protect workers from AIDS and hepatitis B will add to these costs. Obviously, laboratories understand the necessity of protecting their workers; however, implementing these precautions is expensive.

In addition, comprehensive quality assurance regulations recently issued pursuant to Medicare and the Clinical Laboratory Improvement Act of 1967 (CLIA'67), which are scheduled to go into effect later this year, will require most independent clinical laboratories to spend increasing amounts on regulatory compliance. Other regulations implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA'88), which were published on May 21, 1990, will, when effective, require further expenditures.

Moreover, the laboratory industry is highly labor intensive, and salaries for the skilled individuals necessary to do testing have increased dramatically in the last few years. Based on national data, for example, the salaries of

---

1/ We are enclosing as an attachment a series of charts demonstrating these dramatic cuts in reimbursement for laboratories.

2/ Statistical Abstract of the United States, 1989, at 469; Bureau of Labor Statistics, U.S. Department of Labor, CPI Detailed Report, January 1990, at 156.

3/ Id.

4/ Bureau of Labor Statistics, 1989, U.S. Department of Labor, CPI Detailed Report, January 1990 at 161.

chief medical technologists and of staff medical technologists have each increased by well over 30 percent. In addition, it is expected that the salaries of cytotechnologists, which have grown dramatically over the past few years, will continue to rise as a result of the increased demand for these individuals that will result from the workload limitations imposed by new federal regulations.

Finally, when compared with other Medicare expenditures, testing performed by independent clinical laboratories is cost-effective. In 1988, the last year for which actual data is available, Medicare spent approximately $29.97 per Part B enrollee on independent laboratory-provided testing, an amount that is far lower than the average expenditure for other Part B services provided by physicians ($954.15) or hospital outpatient departments ($249.05).[5/] Even more significant, however, is the economic and human savings that laboratory testing provides through early diagnosis and detection of disease triggering prompt medical intervention, enhancing the likelihood of recovery, and reducing both the human suffering and the amounts that would have been spent had the disease continued undiscovered. This is the area in which lab testing really proves its cost-effectiveness! Thus, in the face of escalating cost burdens, laboratories have seen their actual Medicare reimbursement decreased year after year.[6/]

C. The Administration Proposal

With this background, we now review the Administration's FY'91 budget proposal for Medicare reimbursement of clinical laboratories. As noted above, the Administration has offered a broad package of proposals which appear to be designed not to meet the necessary budget targets, but to basically restructure the method by which laboratories are reimbursed. The Administration's proposals are: (i) a reduction in the national limitation amounts, which act as a "ceiling" on laboratory payments, for most individual tests to 90 percent of the Medicare fee schedule medians; (ii) a reduction in the national limitation amounts for profiles and "standardized test packages" to 80 percent of the fee schedule medians; (iii) a CPI update on fee schedule amounts below the national limitation levels; (iv) a requirement that laboratories report the price charged to the test-ordering physician when he or she orders a particular test for a non-Medicare patient; and (v) implementation of a competitive bidding demonstration for laboratory services.

While the Administration has stated that this package of proposals will save about $60 million in FY'91, they could actually cause substantially larger

---

5/ See Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: 1990 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund at 46. This statistic covers independent laboratories only; it does not include physicians' office or hospital outpatient laboratories. It should also be noted that the Trustees Report estimates that in 1990 independent laboratory expenditures will account for less than three percent of the money spent for each Part B enrollee. Id.

6/ Significantly, reimbursement for most other services has increased somewhat since 1984.

reductions, especially in out-years. The Congressional Budget Office (CBO) has reported that just the first three provisions listed above will likely save $85 million in 1991.

Because ACLA understands the need to reduce the mounting federal deficit, it is prepared to refrain from opposing the Administration's proposal to reduce the national limitation amounts to 90 percent of the fee schedule medians.7/ The Association's initial review suggests that this reduction alone could achieve a substantial reduction in Medicare payments.

In addition, ACLA supports the Administration's proposed update of the fee schedules. Although the amount of the update is not specified, ACLA urges the implementation of an update reflecting the full increase in the CPI. Further, ACLA urges that the national limitation amounts also be updated before reduced limitation amounts are calculated. In this way, the reimbursement received by laboratories that are subject to the new national limitation amount will be adjusted to reflect the effects of inflation.

ACLA believes that the Administration's other proposals will have serious deleterious effects on the quality of and access to laboratory testing services. These proposals appear to stem from a desire not to save money but to restructure the way in which laboratories are reimbursed. If this is true, then ACLA believes there should be a full airing of the issues involved, rather than an attempt to radically revamp the industry through the budget process. In addition, as noted above, many of these provisions are not necessary to reach the $60 million that the Administration wishes to save on laboratory expenditures. Further, as noted, the industry is currently preparing for the effect of two new sets of laboratory regulations. This hardly seems the time to implement a major restructuring of the industry that will further reduce reimbursement. Finally, as discussed in greater detail below, there are other more reasonable and more effective solutions if the Administration (and Congress) truly wish to restructure the test delivery system.

1. Reduction in the National Limitation Amounts for Profiles

The Administration is proposing to establish new national limitation amounts for profiles and "standardized test packages," which would be set at 80 percent of the fee schedule medians. Although it is unclear what is meant by "standardized test packages," as it is not a term commonly used in the laboratory industry, it is believed that the Administration intends this provision to apply to test panels, as well as profiles.

Profiles are groups of tests that are ordered as a package, that are conducted individually and frequently on different instruments, and that are often performed on different specimens. Physicians order profiles because it is

---

7/ In recent years, ACLA has endorsed the achievement of laboratory savings through reductions in the national limitation amounts, as this methodology encourages efficiency and is more equitable than other approaches to spending cuts. The most important question, of course, is what the appropriate level for the national limitation amount is.

more efficient and convenient for them to do so. It is easier for a physician to order a single profile than request numerous individual tests. Moreover, profiles represent good medical practice, as they may lead to the early diagnosis and treatment of medical conditions, a result that ultimately saves Medicare expenditures through early detection of disease. Although profile ordering results in a substantial reduction in the paperwork and time required of the physician and his or her staff, the laboratory bears the same costs as it would have borne had each test been ordered individually, because each testing procedure must be performed individually.

Unlike profiles, panels are automated tests performed on a single specimen on a single instrument. By doing a single panel, a laboratory may actually perform as many as 24 or 25 different types of analyses. While panels have been assigned procedure codes, most profiles have not been. Both panels and profiles represent appropriate laboratory testing practice that is in the best interests of the patient.

Currently, HCFA has directed carriers to reimburse for panels at a single price just as they would for any test. This is a reasonable approach, as a panel is in reality just like any other individual test. However, for this reason, there is also no reason to reimburse panels using a formula different than is used for other individual tests, which is what the Administration proposes. Moreover, panels have already been subject to a fee schedule rebasing which reduced payment by 8.3 percent (see OBRA'87).

In the case of profiles, HCFA has instructed carriers to reimburse for each individual test included in a profile, where no procedure codes have been assigned, but to pay no more for the aggregated total of tests than would be charged patients and other third-party payors for the profile. ACLA members bill Medicare for profiles in accordance with HCFA's instructions.8/ ACLA members also provide Medicare the same profile concessions as are supplied to other third-party payors. Thus, if the tests would cost a physician's non-Medicare patient $75.00 when billed separately, but would only cost $50.00 as a profile, Medicare is billed only $50. As a result, Medicare receives the same benefits as other third-party payors. Accordingly, there is simply no reason to enact a separate reimbursement formula applicable to this type of test package.

2. Reporting of the Price To Test-Ordering Physician

The Administration has also proposed that independent laboratories report to Medicare the price charged to the test-ordering physician when he or she orders the same test for a non-Medicare patient. The Administration has indicated it would use this information to reduce the fee schedules in the future, although no

---

8/ HCFA is now studying whether carriers are enforcing its policy. It is also studying whether profiles should be assigned procedure codes and whether profile national limitation amounts should be established. Thus, the agency is acting to ensure that Medicare does not overpay for profiles and to correct situations in which overpayment is discovered.

specifics are available concerning how this reduction would be effectuated.[9] This proposal is an attempt to revamp the entire structure of laboratory pricing by forcing laboratories to provide Medicare the same price given to physicians for non-Medicare testing. However, there is simply no reason why physician prices should be used as the basis for a recalculation of the Medicare fee schedule.

Physicians often request pricing concessions from laboratories, and laboratories frequently grant these requested concessions, when such physicians order tests for non-Medicare patients and when such physicians decide to pay the laboratory for the service. There are a number of reasons for this practice. As an initial matter, independent laboratories have no testing to perform without test orders from physicians. As a result, physicians have significantly more bargaining power than laboratories. In addition, when a laboratory bills a physician directly, it does so on a monthly basis and provides relatively little information other than the patient's name, date of service, and services performed. The physician acts as the middleman in this transaction, collects from the appropriate third-party payor or patient, and assumes the risk of nonpayment. Medicare, on the other hand, requires a laboratory to provide a great deal more information, which is often difficult, time-consuming and expensive for the laboratory to obtain. In many instances, the laboratory does not have this information, but must obtain it from physicians who are often unresponsive to requests that they supply it. As a result, it is usually more expensive for laboratories to deal with Medicare than with physicians. Congress recognized this fact in 1984, when it required that the laboratory fee schedules be calculated from prevailing charges based on prices paid by patients and third-party payors, rather than on amounts paid by physicians.

Moreover, when physicians order tests, the increasing volumes result in economies of scale that lower a laboratory's costs; however, Medicare does not order tests and cannot ensure a laboratory an increased volume of tests. Thus, although Medicare may be a large payor of testing services, it is not a large purchaser of testing services, and it is fallacious to argue that Medicare should receive the same price as true large volume purchasers, such as physicians.[10]

Finally, compliance with the Administration's reporting proposal would be incredibly burdensome.[11] Each time a laboratory billed Medicare it would have to determine what it would charge a particular physician for the specific test. Laboratories offer thousands of tests to thousands of physicians at changing and

---

9/ For example, would the fee schedules just be reduced to the lowest physician price or would all the prices be arrayed with the new fee schedule set at some percentile? Would the frequency at which a particular price was charged be taken into consideration?

10/ ACLA has prepared a position paper discussing proposals that Medicare payment should be tied to prices charged to physicians which it will supply to the Committee if it wishes.

11/ ACLA notes that the federal government already has substantial information about laboratory charges to physicians. Thus, the proposed requirement, in addition to being unduly burdensome, is unnecessary.

often individualized prices. In 1984, when Congress enacted the current fee schedule methodology, it instructed HCFA to streamline the Medicare billing process--a requirement that HCFA has done little to implement. The new proposal would add an additional, highly burdensome requirement, which would only further increase the laboratory's costs of dealing with Medicare. For all these reasons, ACLA strongly opposes this reporting proposal.

3. Competitive Bidding Demonstration

The Administration has also proposed implementation of a competitive bidding demonstration for laboratory services. Like the other proposals discussed above, this proposal represents an attempt to radically restructure Medicare's laboratory reimbursement system. Although there is no description of the plan in the budget proposal, ACLA expects it would be based on an earlier proposal developed by a health care consultant working under contract with HCFA. When HCFA tried to implement this plan in the past, serious weaknesses in the proposed model prompted Congress to repeatedly block implementation.12/ ACLA urges Congress to reject this proposal for all the reasons set out below.

Competitive bidding for laboratory services is not a new idea. In late September, 1985, HCFA entered into a contract with Abt Associates of Cambridge, Massachusetts to design, implement and evaluate a competitive bidding demonstration for procuring laboratory testing services reimbursed by Medicare. No final description of the project was ever issued publicly nor was the industry ever given an opportunity to comment on the final plan.

Under the Abt model, independent laboratories that wished to bid would have to agree to provide specified tests, either in-house or by arrangement with other labs. Winning independent laboratories would be paid at winning prices; losing independent laboratories would be paid at prices below the winning bid. In fact, the higher a losing laboratory's bid was above the winning bid, the lower its reimbursement would be.

Only independent laboratories were required to bid to participate. Physician office laboratories would be precluded from bidding but would still be paid at bid winning prices. Hospital laboratories might or might not have to bid, depending on whether they provided services to non-patients, in addition to hospital outpatients. Although the Administration proposal does not specifically mention the Abt model, it seems reasonable to assume that this plan was the inspiration for the inclusion of the Administration's competitive bidding provision. Moreover, many of the differences discussed below are endemic in any competitive bidding plan--not just the Abt proposal.

ACLA has a number of specific objections to competitive bidding for laboratory services. However, its major objection can be summed up simply: competitive bidding simply will not ensure quality laboratory services at low prices and could harm beneficiaries. The system virtually ensures that there

---

12/ A similar moratorium was originally included in the Senate Finance Committee reported version of OBRA'89; however, it was "stripped" before Senate passage.

will be a serious deterioration in the quality of testing services. In fact, in other instances where competitive bidding was attempted, some laboratories submitted unreasonably low bids to win the contract but then could not cover the costs of providing the services and were forced to cut corners--with disastrous results. For example, when the Air Force awarded a contract to a laboratory for screening Pap smears of female dependents of servicemen on the basis of competitive bidding, the winning laboratory performed so negligently that women's lives were placed at risk. The Air Force was forced to impound over 700,000 Pap smears which they found contained numerous errors. Other attempts to use competitive bidding for laboratory services have met with similar fates.[13/]

The treatment accorded "losing" laboratories under the Abt Model is especially disturbing. These labs would be reimbursed at levels substantially below both their bid price and the "winning" bid price. If the losing entities initially bid prices that they believed were realistic from a cost and competitive standpoint, then it follows that they would be reimbursed at a level that might not even allow them to cover their costs. As a result, they would find it difficult to provide quality services. Moreover, laboratories that found they were losing money on Medicare work could be forced to close or merge, leading to increased concentration in the industry and decreased access for beneficiaries.

These problems are exacerbated by the fact that the Abt model, unlike most competitive bidding models, does not guarantee any volume of testing to the winners.[14/] Thus, a laboratory would have no way of estimating what its volume would be when it was formulating its bid. This fact would make it extremely difficult for laboratories to develop intelligent, rational bids that reflected the cost of providing a particular volume of service. Because there is no way to assure that the bid price would relate to the actual cost of providing the service, the quality problems noted above would be virtually assured. To risk such a deterioration in quality when Congress has just recently passed CLIA'88, which is designed to ensure high quality, seems dangerous and counterproductive.

Further, the Abt model treats the three categories of laboratory competitors--physician office, hospital and independent--differently, thereby undercutting many recent legislative reforms that were designed to ensure a level playing field among various classes of labs. As envisioned by the Abt model, physician office laboratories would automatically be paid at the bid winning price. Those hospital laboratories that provide testing to hospital non-patients would be treated in the same fashion as independent laboratories. For hospitals that perform testing only on hospital out-patients, however, bidding would not be

---

13/ See J.R. Schenken, M.D., "Caution on the Slippery Road to Competitive Bidding," Medical Laboratory Observer at 57 (March, 1983).

14/ In the usual instance, of course, competitive bidding requires a firm to offer a lower price in exchange for an assurance of increased volume. Abt correctly avoided such a practice because of its concern that the quality problems discussed above would result. However, without some idea of volume, it impossible for participants to formulate a reasonable bid. It is this inherent contradiction that makes it impossible for competitive bidding for Medicare laboratory services to succeed.

required, but these hospitals would be paid at bid winning prices.

Numerous problems are created by this aspect of the proposed design. Independent, hospital and physician office laboratories compete for testing business. In fact, physician office and hospital laboratories have a natural advantage in this competitive battle, as they have captive patients that they control. Independent laboratories have no such benefit because they have no patients of their own and are dependent on a physician request to trigger the testing process. Despite this competitive disadvantage, it is the independent clinical labs that would bear the greatest risk of being reimbursed at a level below the winning bid if they were classified as "losers." Physician office labs would never bear that risk and hospitals would only bear it if they provided services to non-patients. Obviously, this plan effectively destroys the "level playing field" created by recent legislation, the purpose of which was to ensure that all laboratories--physician office, hospital, and independent--are treated the same by Medicare payment rules.

Moreover, even if the Abt plan were only implemented as a demonstration, it would be both expensive and burdensome. Today, each carrier reimburses laboratories on the basis of a single fee schedule. Under the competitive bidding plan, specific pricing information would have to be retained for each of the participating laboratories. Finally, because of the quality problems inherent in competitive bidding, even a demonstration project presents great risks to patients whose testing is included in the project. For all of these reasons, ACLA opposes the Administration's competitive bidding proposal.

4. Summary

With the exception of the reduction in the national limitation amounts to 90 percent and the CPI update, ACLA opposes the Administration's proposals for clinical laboratory testing services. As discussed above, these provisions appear to represent an attempt to effect major restructuring of the clinical laboratory testing market under the guise of the budget process. Further, such revamping would wreak havoc in the industry, harm quality care and reduce access. If Congress is interested in changing the delivery of testing services, ACLA urges it to consider the proposal set out below.

D. ACLA's Alternatives

ACLA has two proposals designed to promote a fairer and more equitable laboratory reimbursement system. First, ACLA notes that a recurrent problem that has made rational decisionmaking in the laboratory field difficult is HCFA's failure to maintain separate statistics for physician office and hospital outpatient laboratories. As noted above, HCFA does have separate statistics for independent laboratories; however, independent laboratories only account for approximately a quarter of Medicare laboratory service payments. Because there are no statistics on the other two, larger sectors of the industry, it is impossible to track the effect of various legislative initiatives in the laboratory field. Therefore, we urge the Committee to require HCFA to collect separate information on the utilization of physician office and hospital outpatient laboratory services so that this information can serve as the basis for future legislative efforts.

Second, if the Administration (and Congress) wish to reform the structure of clinical laboratory testing, then the proposals discussed above should be rejected, and instead, direct billing legislation, which would prohibit physicians from billing for tests that they do not perform, should be enacted. Direct billing would correct the problems that were the impetus for most of the Administration's proposals, without their unfortunate side-effects on quality and access.

Under the current system, in most states a physician ordering a test for a non-Medicare patient can either request that the laboratory bill him or that it bill the patient or third-party payor directly. If the laboratory bills the physician, then he pays the laboratory, and bills the third-party payor or patient, in an amount that usually exceeds the price that the laboratory charged him. The physician thus earns a profit on this testing, even though he plays no role in the testing process other than periodically taking the specimen and sending it to the laboratory. This mark-up may compromise physician decisionmaking, lead to over-utilization and result in the selection of a laboratory for reasons other than the quality of its service.

As the government has lowered Medicare reimbursement to laboratories since 1984, it has placed physicians in a pivotal position vis-a-vis laboratories. Because laboratories cannot perform testing without a physician's order, physicians can force laboratories to grant substantial discounts if the laboratory wishes to obtain a physician's patronage. As noted above, to some extent, these lower prices may be justified by the lower costs of dealing with physicians; however, in some cases, the increasing competition for physician business may result in physicians receiving prices that are excessively low. Physicians can then mark up these prices by substantial amounts when billing patients and third party payors.[15/] Thus, patients and third-parties pay substantially more for testing than physicians or Medicare, which reimburses at levels that are significantly lower than the prices that it is billed.

Thus, there is in effect the following "Alice-in-Wonderland" situation. Physicians act as brokers of laboratory services, paying the lowest amount because they control the volume of testing. Although physicians have no involvement in the testing process, they are permitted to mark-up these tests by huge amounts, the costs of which are borne by third-party payors and patients. Medicare pays the next lowest amount, as the government has protected itself through implementation of the fee schedules and the national limitation amounts. Finally, patients and third-party payors pay the most. Reducing Medicare prices to the same amount that physicians pay, as the Administration may be implicitly proposing, will only make this situation worse. The solution is not to have Medicare pay the same price as physicians; it is to remove the physician completely from this calculus.

Accordingly, the federal government should do for the private sector what it did in 1984 for Medicare, namely, require laboratory "direct billing" to patients and third parties by prohibiting labs from billing physicians. Such an enactment would eliminate physician markups, incentives to overutilize testing services,

---

15/ Further, because physicians earn substantial profits on each test that they order, they also have an incentive to overutilize testing services.

and practices that impair quality. Laboratories could adopt a more rational pricing system that would benefit third-party payors, patients and Medicare, as laboratories would no longer be forced to adjust for unjustified physician discounts.

Direct billing would also mean that price competition among laboratories could take place at the patient and third party level instead of at the physician level where benefits do not accrue to patients and third parties. New York State has long had such a direct billing system and, as a result, patient prices are significantly lower in New York than the national average. One ACLA member notes its revenues per test in New York for non-Medicare patients and third parties is 20 percent lower than the average of its other labs.

Moreover, because the Medicare fee schedules were originally set based on prices to patients and third-party payors, Medicare prices in direct billing states are substantially lower than in other states, a fact that demonstrates the financial benefits of direct billing. In fact, ACLA members report that per test Medicare reimbursement in Michigan and New York--both of which are direct billing states--is substantially lower than per test reimbursement in non-direct billing states.

Direct billing would reform the laboratory industry in a beneficial way without injuring quality or access. It would reduce the disparity between what private patients pay and what Medicare reimburses for laboratory tests, and it would permit Medicare to gradually reduce the amount it reimburses without endangering quality and access for Medicare patients.

Conclusion

ACLA urges that, if necessary, Congress reduce the national limitation amounts for all tests to 90 percent of the fee schedule median and approve a full CPI update for fee schedule rates below the national limitation amounts and for the national limitation amounts themselves. The remaining proposals should be rejected. Finally, Congress should consider the adoption of direct billing legislation and should mandate that HCFA maintain additional laboratory-related data.

STATEMENT OF THE AMERICAN ORTHOTIC AND PROSTHETIC ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON ENERGY AND COMMERCE ON PROPOSALS TO REDUCE
MEDICARE PART B BUDGET OUTLAYS
July 27, 1990

I. INTRODUCTION

The American Orthotic and Prosthetic Association (AOPA) is the association representing the 1,100 facilities that provide orthotic and prosthetic care to the physically challenged throughout the United States. Practitioners employed by AOPA members design and fit braces and prostheses that enable these physically challenged individuals to overcome often serious and crippling injuries and return to productive lives. AOPA appreciates this opportunity to comment on Medicare budget reduction proposals.

II. BACKGROUND ON THE ORTHOTIC AND PROSTHETIC INDUSTRY AND MEDICARE REIMBURSEMENT

Orthotic and prosthetic (O&P) services involve the patient care activity of a highly-trained, certified allied health practitioner who evaluates the needs of each individual patient, often in emergency situations, and consults closely with the prescribing physicians to ensure that the patient is fit with the proper orthosis (brace) or prosthesis (artificial limb) for his or her individual needs. The O&P specialist then designs and fits the orthosis or prosthesis for the patient. Once the initial fitting is done, the orthotist or prosthetist continues to work with the patient, instructing him or her how to properly use the brace or prosthesis and conducting follow-up care throughout the course of the patient's disability or rehabilitation to ensure that the brace or prosthesis continues to fit properly and is properly used by the patient.

The O&P field is a relatively small one, with only about 2,600 certified practitioners available to serve the entire United States. The services of this industry are rehabilitative in nature. Typically, they reduce the length of stay for beneficiaries in costly inpatient settings and help restore mobility and ability to function unaided, making it possible for the O&P patient to return to useful work.

Orthotic and prosthetic services have been covered by Medicare since the inception of the program. However, in the Omnibus Budget Reconciliation Act of 1987 (OBRA'87), Congress adopted a drastic change in the reimbursement methodology for O&P services. OBRA'87 mandated the Six Point Plan, a new fee schedule reimbursement methodology for durable medical equipment (DME), and included O&P services in the plan. Medicare carriers

and O&P practitioners are still struggling to resolve errors in the new fee schedules. Congress has directed the Health Care Financing Administration (HCFA) and the General Accounting Office (GAO) to conduct studies on the impact of the new payment methodology. These reports are not due to Congress until the end of this year. However, in testimony May 22 before the House Ways and Means Committee on its preliminary findings, the GAO cited wide and unexplained geographic payment variations for numerous DME products and O&P services.

III. PROPOSAL TO REPLACE "SIX POINT PLAN" FOR O&P

The O&P field did not write, seek or endorse the Six Point Plan, and maintains that O&P has been inappropriately lumped together with a group of providers who do not comprise an allied health discipline, but rather sell or rent products to support certain treatment modalities. This situation has been exacerbated by the many difficulties experienced by the O&P field, by HCFA, and by the 58 Medicare carriers during the implementation of the Six Point Plan, because the system has not been designed to address the inherent differences between O&P and DME. The failure of the "Six Point Plan" to address these inherent differences has resulted in (1) inconsistencies in coverage decisions and (2) wide geographical differences in payment. As noted above, GAO's own investigation thus far has revealed these problems. A study AOPA commissioned from Ernst & Young in 1989 shows these and other ways in which the Six Point Plan has adversely affected Medicare reimbursement of O&P. The following three AOPA proposals would address these problems and help reduce Medicare budget outlays.

A. Legislative and Regulatory Separation of O&P from DME

First, O&P should be legislatively separated from DME for all Medicare purposes. Such separation is necessary because of the wide differences between O&P and DME. O&P is entirely different from DME in that the O&P service is individual to the patient and is as much a professional service as a product. The "product" element of the O&P practice (the brace or prosthesis) is only part of the total package of medical care provided by an O&P practitioner. Unlike DME, the brace or prosthesis is typically not a "product" at all in the sense that it can be used again by another patient. O&P services require a physician's prescription, and thus utilization cannot be stimulated by direct appeals to the patient through advertising and promotion of a fungible "product." O&P devices are generally custom-fabricated and custom-fit for each individual patient, unlike DME products, which are reusable or rentable by another patient.

Indeed, because of the unique combination of personal medical service and skill with a physical object (brace or

prosthesis) provided by the O&P field, O&P Medicare reimbursement since the 1970s has used a unique set of codes ("L"-codes). The codes were specifically designed by HCFA, in consultation with the O&P field, to reimburse both the professional service and "product" elements of O&P within a single code.

Further, the O&P medical field is completely different from DME in that O&P has a defined body of clinical knowledge, a certification program to ensure that practitioners have sufficient education, training and skill to meet the complex needs of rehabilitation patients, a well-established baccalaureate educational program in ten major universities, and intensive professional involvement between practitioner and patient.

The subsuming of O&P within the completely different category of DME has had serious adverse affects on the O&P profession in the last several years. Most significantly, this inappropriate melding of two very different medical services resulted in the application to O&P of the Six Point Plan without input, assessment or preparation from the O&P industry. The problem persisted in OBRA'89, when Medicare budget proposals for DME were (without explicit statement) held to cover O&P as well. This confusion caused policymakers inadvertently to consider action dramatically affecting the O&P industry without the benefit of cost estimates or Administration explanation as to how such proposals might specifically affect O&P practitioners.

Thus, the O&P field's foremost request of policymakers is that this field be treated and evaluated differently from DME by Medicare. The separation of O&P from DME will serve to ensure that the O&P provider will be reimbursed in a fair and equitable way as well as afford the Medicare beneficiary continued access to quality O&P health care services.

B. Reduced Number of O&P Carriers

AOPA's second proposal is that the number of Medicare carriers be reduced for O&P claims processing. There are currently 58 Part B carriers responsible for making payment to providers of O&P patient services. By law, carrier participation in the Medicare program is contingent upon their meeting criteria designed to promote the more effective and efficient administration of the Medicare program. However, the current carrier structure for orthotic and prosthetic patient services is not effective or efficient and has contributed to the problems of inconsistent coverage decisions and payment variations. The O&P field is extremely small (only 2,600 practitioners nationwide); therefore, carriers have little opportunity to develop sufficient expertise and data to render sound coverage and reimbursement decisions. The handling of O&P patient care claims by a large number of carriers has been characterized by inappropriate and

inconsistent coverage decisions -- confusing patients, practitioners, and prescribing physicians. In addition, the administrative cost of providing O&P reimbursement is unnecessarily high when program administration is spread among 58 carriers.

HCFA has already recognized the benefits of the supercarrier concept (a small number of carriers for the entire nation) to address provider concerns about inappropriate and inconsistent coverage decisions and to provide efficiency in operations. This method was implemented in the parenteral and enteral nutrition (PEN) and home care areas in the mid-1980s and has proved useful in achieving consistency in coverage decisions, operational efficiency and cost-effectiveness. Recently, HCFA has established a special task force to address problems caused by the multiplicity of carriers. AOPA supports this effort, and asks Congress to direct the agency to expand its use of supercarriers to O&P.

The organized field of O&P proposes, under the authority of 42 U.S.C. §1395m(a)(12), that the number of designated carriers authorized to handle the administration of Part B O&P claims be reduced to two carriers nationwide for the following reasons:

1. More Uniform Interpretation of Medicare Rules - HCFA's guidelines are subject to interpretations by carriers. Reducing the number of carriers responsible for interpreting Medicare rules will reduce the number of inconsistencies, thereby providing a more uniform standard of patient care for Medicare beneficiaries.

2. Expertise in Claims Processing - Decreasing the number of designated carriers will give these carriers a volume of O&P claims sufficiently large to develop an expertise in O&P claims processing. This experience should result in more consistent and accurate coverage determinations and new claims processing efficiencies.

3. Control of Administrative Costs - As administrator of the Medicare program, HCFA seeks to control or reduce administrative costs by means that will not harm the level and quality of service provided to beneficiaries. Concentrating the workload from a particular class of providers in fewer carriers has the potential to achieve these goals through cost avoidance. At present, there is not a standardized automated claims processing system in use by all carriers. Consequently, when a Medicare program change requires a change in the automated claims processing system, HCFA must fund this activity at 58 sites. Absent a standard system, substantial administrative dollars could be saved by reducing the number of carriers processing O&P claims.

4. Ease of Communication with Members of the O&P Field - It is important that Medicare program policy be clearly and uniformly understood by Medicare carriers if consistency in coverage and reimbursement determinations is to be achieved. It is currently difficult to ensure this because of the large number of carriers involved and because guidelines, no matter how well written, are frequently subject to interpretation.

   Communication of O&P program policy would be facilitated, as well as less costly, if the number of carriers processing O&P bills were reduced. HCFA's resources could, therefore, be used more efficiently and effectively.

5. Ease of Data Collection - The collection and maintenance of data are vital to efficient and effective program administration. Collection and verification of O&P data would be facilitated if the number of carriers were reduced to two. At present, HCFA must collect and verify data from 58 sites.

6. Ease of HCFA's Monitoring of Carrier Performance - Monitoring of carrier performance requires considerable expenditures in time and personnel. Monitoring carrier performance with respect to O&P health care providers would be improved if HCFA needed to focus its attention on only two carriers rather than 58 carriers. This more effective use of resources should lead to earlier identification of problems and quicker corrective actions, and would help ensure that Medicare beneficiaries receive the appropriate levels of health care.

C. Revised Medicare Reimbursement System for O&P

AOPA's third proposal is that Congress direct HCFA to modify the current reimbursement of O&P. While the development of the present L-code section of the HCPCS promotes fair and equitable reimbursement through uniform description of the O&P devices, encroachment into the system by other types of providers has resulted in commingled data in the database used by Medicare carriers to calculate reimbursement. This has made the determination of accurate reimbursement very difficult for Medicare carriers and caused a serious lack of consistency in payment policies. The dilemma is twofold. (1) The coding system is misused, because in some cases, reimbursement is based on mistakenly coded data leading to inconsistent coverage decisions. (2) Reimbursement levels are affected by non-O&P providers' charges, leading to wide variations in payment. Many non-O&P charges are those of other service providers, whose charges for O&P codes are frequently artificially low because, unlike O&P practitioners, they can also bill for office visits.

AOPA is presently refining a plan to address these problems through some fairly simple coding changes and other means. The proposal is designed to recognize the inherent differences between the service and nonservice health care providers who use the O&P L-codes. It will help address policy inconsistencies and payment variations. As a result, both service and nonservice providers are likely to be reimbursed in a more fair and equitable way, which will ultimately benefit the patient beneficiary.

IV. MEDICARE BUDGET PROPOSALS FOR FISCAL YEAR 1991

The Administration has made the following budget proposals for fiscal year 1991 (FY'91) that would affect O&P practitioners.

First, the Administration has proposed to cap reimbursement at the median of all local fee schedules. Second, the Administration has proposed that local fee schedule payments that are at or above the national median cap would receive no payment updates. Third, the Administration proposes to "give serious consideration" to competitive bidding demonstrations for DME.

Before discussing these proposals, AOPA notes that this year, as in the past few years, budget proposals for DME have been treated as including O&P -- notwithstanding the fact that the two are completely different. As noted earlier, O&P should be legislatively separated from DME for all Medicare purposes, including budget proposals and savings estimates.

AOPA has not yet formulated a final position on the Administration's DME proposals this year, in part because some of them have not been presented with sufficient detail to permit a thorough evaluation. However, the Association does wish to identify certain factors, specific to the O&P field, that Congress should be aware of in considering these proposals with respect to O&P.

With regard to the national median limitation and no-update proposals, AOPA believes the Six Point Plan should be eliminated for O&P and does not oppose the concept of a national system to replace it. However, AOPA is concerned that a cap at the current national median, which reflects many artificially low non-O&P charges, might compromise the availability of O&P services, especially in rural areas. Consequently, beneficiaries might have to travel sometimes hundreds of miles to obtain care. Where care was unavailable, Medicare and other government and societal costs would rise substantially due to longer hospital stays and work furloughs for patients who could not be provided rehabilitative services quickly.

The threat of reduced availability of O&P services already exists due to recent reductions in federal funds for O&P

education -- a costly program of study because of the substantial investment in clinical items and services necessary to provide this education. Without adequate educational funds, O&P practitioners cannot be trained, and thus, cannot replace others in the field who are leaving it due to death and retirement. This problem is particularly acute now because the average age of O&P practitioners is high (in the 50s), meaning that practitioners are already leaving the field much faster than students can be trained to replace them.

With regard to the Administration's proposal for competitive bidding for DME, it is difficult to comment on this proposal at all because no specific competitive bidding model has been described. However, it is possible that competitive bidding might be inappropriate for the O&P industry because every O&P procedure is different. The O&P "L" codes were developed by HCFA as an "add-on" or modular system, with each procedure described by a combination of several modular codes. Consequently, there is no "basic" or "garden variety" artificial limb. Thus, any "competitive bidding" demonstration that is developed for O&P should take this fact into account and be devised in close consultation with the O&P field.

V. CONCLUSION

AOPA urges Congress to deal with the problems in Medicare reimbursement of O&P, including payment variations and coverage inconsistencies, in three ways: (1) a legislative separation of O&P from DME; (2) adoption of a supercarrier concept; and (3) a modified reimbursement system for O&P.

With respect to the Administration's proposals, O&P payment levels and competitive bidding concepts should be considered by Congress in consultation with the O&P field to avoid compromising the availability of cost-effective O&P services.

STATEMENT OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

On behalf of internists nationwide who treat Medicare patients, the American Society of Internal Medicine is pleased to share its recommendations on the proposed FY 1991 budget for Medicare.

ASIM strongly believes that Congress should reject the administration's proposal to the budget summit to slash Medicare spending by as much as $6 billion. According to the General Accounting Office, Medicare has been cut by approximately $36 billion over fiscal years 1981-1987. Payment for physician services alone will have been cut another $15.5 billion over fiscal years 1987-93 due to cuts already enacted by Congress. Common sense tells us that no program can continue to absorb annual cuts of billions and billions of dollars, on top of those already mandated by Congress, without adversely affecting the services provided under that program.

For years, ASIM and other physician organizations have cautioned Congress and the administration that continued cuts in Medicare had the potential of harming quality and availability of care. Perhaps because physicians and hospitals absorbed those reductions without compromising care to patients, those warnings have largely gone unheeded.

But there is now growing evidence that the cumulative impact of the cuts in Medicare is beginning to erode quality and availability. Several recent studies have shown that physician dissatisfaction with the Medicare program is at an historical high. That dissatisfaction, particularly for office-based, primary care physicians, is based on two trends: declining reimbursement for undervalued evaluation and management services, and the increasing administrative burdens--or the hassle factor--associated with the Medicare program. According to the authors of one recent survey of internists, an increasing number of physicians established in practice are considering, or have taken, early retirement. Many are advising younger physicians not to enter primary care specialties. The authors note that the word is beginning to get out to younger physicians:

fewer and fewer are going into general internal medicine. Such surveys are supported by objective data, which demonstrates that internal medicine residency programs have exhibited a marked decline in applicants in recent years.

ASIM is also hearing from a growing number of physicians who are reluctantly taking steps to limit their interaction with the Medicare program. In recent months several physicians called ASIM to find out how they can completely remove their practices from any obligation to provide care to patients that receive benefits under Medicare. Although perhaps an extreme reaction, these calls illustrate the intensity of frustration felt by some physicians. Many other internists report that it has become a common practice for them and their colleagues to instruct their office staffs not to accept any new Medicare patients. Several ASIM members in their prime practice years have recently chosen to leave patient care for administrative, salaried positions, largely in response to their frustrations with Medicare and other third party payors.

Fortunately, most Medicare patients are still able to get good, comprehensive medical care from their own personal physicians. But one can readily foresee that in the next five to ten years, Medicare beneficiaries may find it exceedingly difficult to find a primary care physician, as more and more established physicians choose early retirement, fewer and fewer physicians enter primary care specialties, and increasing numbers of physicians tailor their practices to non-Medicare patients. The current isolated instances of inadequate access to primary care services, such as is the case in many rural and inner city communities, may soon become the norm. By the time that declining numbers of primary care physicians reaches crisis proportions, it will take many years--perhaps decades--to reverse the trend.

ASIM believes that the medical profession has a responsibility to do everything it can to encourage physicians to continue to provide high quality, affordable care for Medicare patients, despite external pressures to do otherwise. We believe that it would be a tragedy for the medical profession, and for the public, for physicians to conclude that they have no choice but to turn away from treating Medicare beneficiaries.

But Congress has a responsibility as well to resist further spending cuts and restrictions on the ability of physicians to provide the best possible care to their patients. It is not reasonable to expect physicians to go along with budget-driven rules and payment policies that require them to provide care that is less than adequate. Physicians want to take care of all of their patients, in the most able and compassionate manner possible. But if physicians conclude that further budget cuts are causing Medicare to demand more and more paperwork as a prerequisite to getting appropriate services reimbursed, to arbitrarily deny more and more medically appropriate services, and to financially punish them for providing the level of care that their patients need and expect, then they may well conclude that they can no longer in conscience go along with such restrictions. Rather than being accomplices to budget-driven policies that they find to be wrong, primary care physicians may instead conclude that going into another specialty, career, or type of practice is the least objectionable course of action.

Consequently, the decisions that Congress makes during the next few years are extraordinarily important, particularly given enactment last year of the Medicare physician payment reform legislation. Primary care physicians are counting on the new RBRVS fee schedule to begin to correct some of the inequities that are fueling dissatisfaction with the program. If the Congress agrees now to budget cuts that will undermine the goals of the fee schedule, physician

disillusionment with Medicare will only intensify and accelerate the trend toward reduced access to services. Whatever remaining trust there now is between physicians and Congress would be broken, perhaps irreparably. If Congress instead acts to preserve physician payment reform, to maintain an adequate level of sustained funding, and to reduce the administrative hassles of Medicare, then physicians are likely to experience a renewed and lasting commitment to Medicare.

In that context, ASIM offers the following specific comments on the administration's proposed Medicare budget and other related issues.

Reductions in Payments for Overvalued Procedures and Localities

The administration is proposing to reduce payments for certain procedures found to be overvalued under the RBRVS fee schedule, to lower payments for services in localities found to be overvalued relative to the national average (after practice costs are taken into account), and to provide for a full Medicare economic index update for primary care services only. The proposed budget presents these proposals as being consistent with long-term reform, arguing that "prior to implementation of the new Medicare payment system, we are proposing additional actions aimed at improving equity in payment levels for both physician and non-physician services."

Unfortunately, however, the budget borrows the language of reform while working to undermine it. While ASIM agrees that at least a full MEI increase for primary care is needed to prevent further erosion in the value of those already undervalued services, the overall emphasis of the administration's budget is to cut payments for physician services, not to produce equity. If the

administration truly was interested in equity, it would have proposed far greater increases in payments for primary care services along with the proposed cuts. Instead, it applies the RBRVS methodology only to justify reductions in payments for overvalued services, not to improve payments for undervalued ones.

Moreover, since 1991 is the base year for determining a budget neutral conversion factor for the new fee schedule, the proposed cuts would require the conversion factor to be set at a proportionately lower level in order to maintain budget neutrality. This could preclude significant improvement in Medicare payments for undervalued services. In other words, *budget cuts this year–even if directed primarily at services that are overvalued compared to the RBRVS–will translate directly in 1992 into smaller gains in reimbursement for undervalued services and localities under the new RBRVS fee schedule.*

The Physician Payment Review Commission (PPRC) agrees. In testimony before the Senate Finance Committee, PPRC Chairman Phil Lee, MD stated that "legislating sharp reductions in payment rates to take effect while we are in the process of implementing a major reform of physician payment could make the achievement of the objectives of reform more difficult. Increasing the speed and magnitude of reductions in fees for services slated to be paid less under the Medicare fee schedule would exacerbate the disruption to physicians and the risk of limitations on access for beneficiaries. Moreover, substantial reductions in the Medicare Part B budget would limit the funds available for the crucial payment increases for evaluation and management services and for care delivered in rural areas." The Congressional Budget Office similarly concludes that further cuts in overpriced procedures "would lower the base for setting new rates [under the RBRVS fee schedule] for all physicians."

ASIM urges Congress not to be taken in by the administration's reform rhetoric. We urge the committee to give at least a full Medicare economic index update to primary care services, and at least a partial update for hospital visits, as recommended by the PPRC. We urge the committee, however, to reject deep cuts in the Part B budget (even if ostensibly directed at overvalued procedures and localities) that would reduce or eliminate future increases in payments for undervalued services under the RBRVS fee schedule.

Payments to New Physicians

In addition to ASIM's strong opposition to the overall magnitude of Part B cuts proposed by the President, we are particularly concerned about the proposal to permanently extend limits on reimbursement to new physicians. In the past, limiting payments to new physicians to a percentage of prevailing charges was rationalized on the basis that they lacked their own customary charge profile, and that was unfair to established physicians to set the charges of new physicians at a level that was higher than many of their colleagues already in practice. Once the RBRVS fee schedule is implemented, however, there is no need to develop a methodology for establishing customary charges for new physicians. Fairness and administrative simplicity would argue for new physicians to receive the same level of reimbursement as any other physician for a service involving the same resource costs. We urge the committee to reject this proposal.

Clinical Laboratory Services

Under the administration's proposed budget, clinical laboratory services would be subject to major reductions in reimbursement. Non-profile tests would be limited to 90 percent of the median fee schedule amounts; profile and standardized test packages would be limited to 80 percent of the median. Fee updates would be permitted only for those tests that are below the new limits. Additional cuts may be proposed as a result of the budget summit.

Clinical laboratory services have been subjected to major reductions in reimbursement for the past several years. ASIM is concerned that further cuts of the magnitude proposed by the administration may make it impossible for physicians to continue to provide testing in their offices, particularly given the increased costs that will be incurred by physician office labs in meeting the new quality requirements mandated by the Clinical Laboratory Improvement Act of 1988 (CLIA '88). The proposed regulations subject physician office laboratories to expensive regulatory requirements under CLIA, including certification and accreditation fees, personnel requirements, participation in proficiency testing programs, and the costs of complying with external paperwork demands and internal quality assurance guidelines.

The dual impact of the costs of complying with CLIA, and reduced Medicare payments, may force many physicians to close their laboratories. The result would be a significant loss of access and greater inconvenience to Medicare beneficiaries. ASIM urges the committee to preserve patient access to in-office testing, by rejecting the administration's proposal to require draconian cuts in payments at the same time that physicians are likely to incur significantly higher expenses in complying with CLIA's new regulatory requirements for physician office labs.

We also urge the committee to use its oversight authority to assure that HCFA's implementation of CLIA '88 preserves Congress' original intent of improving quality which maintaining access to laboratory services. Unless HCFA's proposed rule to implement the Clinical Laboratories Improvement Amendments of 1988 is substantially modified, many physician and rural hospital labs will close.

Members of this committee may have heard from constituents who are concerned that the rule would treat many office labs doing less complex tests the same as commercial labs doing far more sophisticated and risky tests. Many small office labs would be required to hire a pathologist and specially-trained technologists. The expense of doing so, and the fact that there are simply not enough people with the requisite training to go around, would force physicians to close their labs. Patients would wait longer for results and have to travel to large, impersonal commercial labs.

Fortunately, it is not too late to do something. The American Society of Internal Medicine (ASIM), representing America's specialists in adult medical care, urges the committee to write to Gail Wilensky, HCFA's administrator, and request that she:

1. **Revise the rule to reduce any adverse impact on access to laboratory services, including physician office labs.** Congress intended for CLIA '88 to ensure that all labs meet standards that are appropriate for the kinds of tests that they do. It never intended to regulate most physician labs out of existence.

2. **Revise the Level II personnel standards so that they strike a balance between assuring adequate training and preserving access to laboratory services.** Although HCFA's proposed Level II ostensibly includes only the most complex tests, the reality is that many physician office labs doing less complex tests would inappropriately fall under Level II, the highest regulatory category. As a result, they would be required to meet rigid personnel standards. For the kinds of tests done in most physician labs, employing pathologists and medical technologists just isn't needed to ensure accuracy. Other standards in the proposed rule--such as proficiency testing which would require labs to prove that they can do tests accurately--are sufficient. Such labs could be required to arrange for ongoing consultation with those individuals, instead of hiring them on staff.

3. **Revise the rule so that tests commonly done by physician office labs, which are now incorrectly lumped in with some of the most sophisticated tests done by commercial labs, are placed in a lower regulatory category.**

With such changes, CLIA '88 would meet Congress's intent of improving the accuracy of testing while maintaining access to timely and convenient laboratory services.

Competitive Bidding for Laboratory Services

The administration states its intent to give serious consideration to conducting competitive bidding demonstrations for laboratory services in FY 1991.

For the past several years, Congress has appropriately placed a moratorium on competitive bidding for laboratory services, due to concern about its potential impact on quality and availability of testing. Competitive bidding based on price alone could result in laboratories that offer lower quality and less convenient services getting the bid to provide all laboratory services to beneficiaries. It is inconsistent for HHS on one hand to be pursuing implementation of regulations based on CLIA to enhance quality, while at the same time pursuing a competitive bidding policy that could result in bargain basement, poor quality testing. Congress should reinstate the moratorium on competitive bidding for laboratory services.

Voluntary Hospital Participation

ASIM believes that the administration's proposal for voluntary hospital participation agreements--which would allow a hospital to sign a participating physician agreement binding its entire medical staff to accept assignment for emergency services, radiology, anesthesia, pathology, and consultation services--more accurately could be labeled the "Involuntary Physician Participation" proposal. A physician who, as a matter of principle, declines to sign a participation agreement could be bound to accept assignment in the hospital for these services if a majority of the medical staff votes to be a participating physician medical staff. ASIM strongly believes that no physician should be compelled to accept Medicare assignment. Congress wisely rejected mandatory assignment on several occasions in recent years. It should once again reject this back door way to compel some physicians to accept assignment against their own wishes.

Provide Prior Authorization Authority to Carriers

Medicare carriers would be given authority to conduct prior authorization of physician services under the administration's FY 1991 budget proposal.

Given that most Medicare carriers are not applying their current authority for retrospective utilization review in an appropriate manner, ASIM believes that it is not wise to expand the scope of their authority to prior authorization review as well. Physicians increasingly are finding that carriers are denying claims for arbitrary reasons, applying prepayment screens that lack medical input and legitimacy, and demanding excessive paperwork and documentation in order for claims to be paid. Poorly-trained review staff and unwillingness to share screens and payment criteria are contributing to the problem. As noted earlier, the hassles of dealing with Medicare are one of the primary reasons that physicians in growing numbers are opting to limit the number of Medicare patients that they will see, retiring early, going into fields other than primary care, or changing careers. Prior authorization would lead to further hassles–and further physician disillusionment with the program.

Moreover, it is unlikely that most carriers are equipped to handle the volume of requests for authorization that would be demanded. Delays in obtaining needed services and non-payment for appropriate services would be the likely outcome of giving carriers the authority to conduct pre-authorization review.

Until carrier medical review is fundamentally reformed to reduce unnecessary paperwork requirements, to allow for appropriate disclosure of and professional input into medical criteria and screens, and to reduce improper denials of services, it makes no sense to expand the scope of such review. We urge the committee to reject this proposal. At the very least, HCFA should be

required to divulge the services that would be subject to prior authorization (and/or the process for selecting such services), and the way that criteria for authorization would be developed and implemented, before any consideration is given to allowing carriers to institute prior authorization.

Claims Processing Fee

Congress should also reject the administration's proposal to charge physicians a $1.00 "processing fee" for non-electronic claims. The new mandate that physicians file all Medicare claims will in itself add to office overhead. But charging physicians for filling out the paperwork that the program requires is nothing short of absurd. For physicians and carriers that are not able to provide electronic claims processing, it is just another unjustified hassle--and cost--to charge physicians for filing paper claims.

1991 Limits on Balance Billing

Although not a budget-related issue, ASIM urges the committee to address the problems created by the 1991 limits on balance billing.

The requirement that 1991 actual charges for all physician services be limited to no more than 125 percent of the Medicare-approved amount will result in a significant rollback in charges--and substantially decreased Medicare revenues--for many of the evaluation and management services and underserved localities that the RBRVS fee schedule is intended to benefit. We presume that since this is contrary to Congress' basic intent in enacting the new law, it is the result of an unintentional drafting error that could be corrected by a technical amendment.

The problem occurs for two reasons: (1) because Medicare traditionally has paid so poorly for evaluation and management services, particularly in rural areas, the Medicare-approved amount represents a significantly discounted fee compared to what physicians typically charge for those services; and (2) by mandating that lower limits on charges go into effect a full year prior to RBRVS implementation, OBRA '89 forces reductions in charges for already undervalued services, without any concomitant increase in Medicare payments.

In many primarily rural states that are expected to benefit from the RBRVS, the total Medicare "charge reduction" (the percentage difference between the actual charge and Medicare's allowed charge) is considerably in excess of the 1991 balance billing limit. In Wyoming, West Virginia and Colorado, Medicare payments are 30 percent lower than actual charges; in Louisiana, Arkansas, Oklahoma, Texas, Mississippi, Alabama, North and South Carolina, Vermont, Iowa and Georgia, Medicare payments are discounted by between 27 and 30 percent, for example (source: PPRC 1988 Report to Congress). Physicians in those states will now be required on January 1, 1991, to reduce their already low fees to comply with the 125 percent limit on balance billing--even though most of these primarily rural states are supposed to gain under the RBRVS. Similarly, primary care physicians in other states that now (understandably) are charging more that 125 percent above Medicare's low payments for cognitive services will now be forced to lower their fees.

For many internists, the loss of revenue in 1991 as a result of this mandate will place them in an economically precarious position. Although the Physician Payment Review Commission estimated that "only" a small percent of practices nationwide would experience rollbacks, and that the average impact would be less than 5 percent in reduced Medicare revenue, ASIM believes that this estimate may understate the problem. The Society has already provided members of this

committee with specific information from internists on the extent of the problem, which suggests that the magnitude of the reductions may be far greater than previously believed. For those experiencing reductions, the promise of improved reimbursement in 1992 will do nothing to help them pay the bills in 1991. In addition, for those rural physicians who already are having difficulties in recruiting new physicians to their practices, the 1991 rollback will leave them with no glimmer of hope for at least another few years. For beneficiaries, it will be confusing for physicians to lower their fees in 1991, only to raise them again in 1992 as the RBRVS rates (which carry with them increases in actual charges) begin to be phased in.

Although much of the discussion to date has revolved around how many physicians are affected by the rollback, and to what degree, there is another dimension to this issue: the detrimental effect on the credibility of physician payment reform if the rollback is not corrected. Primary care physicians supported physician payment reform because of a belief that the existing payment inequities were wrong. They recognized that other elements of reform--such as limits on balance billing--would inevitably be part of the package. But as long as payment reform improved payments for undervalued services, primary care physicians remained committed to the package.

But now there is a profound sense of disillusionment and betrayal. All along, some advocated that physicians not support payment reform because "no matter what Congress promises, we'll never see any gains in payment." Facing substantial rollbacks, many internists now find themselves agreeing with that sentiment. As one rural South Dakota internist recently wrote, "I personally feel betrayed by the rollbacks occurring prior to the institution of the RBRVS in 1992."

ASIM continues to believe, however, that Congress remains committed to bringing about real increases in payments for undervalued services, particularly in rural communities. On that basis, we supported–and continue to stand behind–payment reform. But we are frankly worried about the credibility of that stance among internists if the fee rollbacks are not averted. What Congress does–or does not do–in the next few weeks will send a powerful signal to physicians on whether or not Congress intends to live up to its end of the bargain.

ASIM continues to believe that the magnitude of the fee reductions is greater than some estimates suggest. But even if only a small percentage of physicians are hurt, the impact on payment reform is more important than the numbers suggest. What is at stake is the credibility of payment reform itself. Please work to preserve the credibility of payment reform by supporting efforts to avert the fee rollback.

ASIM believes that the best approach for correcting the fee rollback for evaluation and management services is to allow physicians in 1991 to continue to charge their current MAACs for those undervalued services only. The OBRA '89 limits would still go into effect for all other services in 1991, and in the following year, would apply to all services, including evaluation and management services. This option would fully avert a rollback for the services that are most undervalued under the current system at no program cost and with minimal impact on beneficiary liability. By comparison, other alternatives would cost significant amounts of money, fail to fully correct the problem, or result in greater increases in liability compared to current law. The attached analysis, citing data from the Congressional Budget Office, explains how ASIM reached these conclusions. ASIM strongly believes that whatever option Congress selects must fully avert the rollback for undervalued evaluation and management services. Failing to correct the problem,

or providing only partial relief for those services, will result in a significant and possibly irreversible loss of credibility in payment reform.

Calculation of the Conversion Factor

As you know, the new fee schedule is the product of the RBRVS and a dollar conversion factor. The manner in which the initial dollar conversion factor is calculated will therefore determine if the new system truly improves reimbursement for undervalued cognitive–or evaluation and management–services, or if it instead perpetuates and exacerbates existing inequities.

For years, many physicians have worried that even if Congress agreed to an RBRVS, it would ultimately be implemented in a way that simply slashes physician fees across-the-board. If the dollar conversion factor is set too low, few (if any) evaluation and management services would see any real increase in reimbursement, while surgical and diagnostic procedures would be subject to severe reductions.

Clearly, that is not the intent of the Commission or Congress. But it may be the intent of the Administration. Although OBRA '89 specifies that the conversion factor for 1992 must be established in a "budget neutral" manner, which would permit real increases in payment for underpaid services and locales, there is considerable discretion given to the Secretary of the Department of Health and Human services on how such a "budget neutral" conversion factor is to be calculated. The Secretary is permitted, for example, to consider "unexpected behavioral changes" in establishing the conversion factor.

The Administration's October 1989 report to Congress, titled "Reports to Congress: Medicare Physician Payment," suggests that the Administration intends to assume that volume will increase substantially under the RBRVS fee schedule, in order to justify a much lower dollar conversion factor than would otherwise be required to maintain budget neutrality. The Administration argues that "Many analysts believe that a resource-based fee schedule could trigger a significant increase in volume, as physicians who face payment reductions under the fee schedule attempt to offset reductions by increasing billings. This, in turn, could lead to a major increase in Medicare expenditures. As a practical matter, some behavioral adjustment must be made when setting the fee schedule conversion factor."

Later, the report states that "It is the position of the Department that the 50 percent response is the most likely (behavioral response to the new fee schedule)." Finally, the Administration argues that "strong arguments can be made to support the view that there are relatively few undervalued services."

If the Administration is permitted to assume a significant "behavioral offset" in establishing the initial dollar conversion factor, all or most of the gains for undervalued cognitive services would be lost. This would not only violate the intent of Congress in enacting the new law, but would also permanently strip the new system of any credibility with the physician community. In that eventuality, the new reform should not endure for much longer.

ASIM strongly urges the Congress to provide specific directions to HHS on how the dollar conversion factor should be developed to maintain budget neutrality and meet Congress' intent that payments for undervalued services be substantially increased. The Congress should

specifically reject the inclusion of any "behavioral offset" in establishing the initial conversion factor. "Unexpected changes in physician behavior" should be factored into the conversion factor only if there is hard evidence, based on actual trends in utilization following the initial phase-in of the RBRVS fee schedule, to justify such an offset. The Administration's apparent intent to assume "a priori" a substantial increase in volume should be recognized for what it is: a thinly-veiled attempt to use the new reform package simply as a budget-cutting tool, rather than as a means to improve equity, access and quality.

Legislation to Reduce the Hassle Factor

ASIM urges the committee to report the Physician Regulatory Relief & Improvement Act of 1990, H.R. 4475, introduced by Representative Roy Rowland on April 4 of this year. H.R. 4475 effectively tackles some of the crucial problems generated by Medicare-related paperwork, which has come to consume nearly one fifth of physician's and their staff's time. Medicare's cumbersome and often unreasonable requirements have greatly harmed the relationship between physicians, carriers, and patients.

If passed, Mr. Rowland's bill will help reduce this adversarial relationship. The bill would eliminate certain cross coverage restrictions that prohibit physicians from billing for colleagues who, during their absence, temporarily care for their patients. By forcing covering physicians to submit charges and establish a file for patients they may see only once, Medicare is imposing an excessive burden on doctors who have limited staff support. Another improvement set forth by the bill is mandating the release of currently confidential screens used by carriers to determine the validity of medical claims. This would allow physicians to modify their behavior in advance of

submitting claims rather than relying on punitive denials of payment in order to obtain program savings. The secrecy of the screens violates the public's right to know whether the parameters are appropriate. Their publication would permit doctors to cooperate with carriers in improving screens to prevent future denial of claims that are medically necessary.

ASIM agrees with Mr. Rowland's proposition that requiring Part B carriers to provide physicians with a complete utilization review "rule book" would lead to improved physician understanding of vital material. If doctors know which screens correspond to the services they render, they are more likely to present sound medical reasons and documentation that adequately supports their decisions. Tired of arguing to no avail, physicians currently end up resigning themselves to not being paid for some services which are in fact of benefit to patients.

Moreover, few individuals have the resources to continually appeal stringent and arbitrary claims denials. Even when such appeals are successful, physicians and patients are frustrated that subsequent claims for the same service for the same patient under the same clinical circumstances, will still be denied. H.R. 4475 addresses this problem by recommending that physicians be allowed to challenge denials on behalf of an entire class of physicians.

Finally, the bill's projected establishment of a Physicians' Advisory Council, comprised of a cross section of specialties who would review Medicare's criteria, would invest Medicare's parameters and rules with sound medical judgement and hopefully, some credibility would be thereby be restored. Physicians would in turn become more receptive to Medicare's stipulations and would modify their behavior accordingly.

Enactment of this bill would be an important step towards reducing the "hassle factor" associated with Medicare which is contributing to increased physician disillusionment with the program and denials of claims for medically appropriate services. Unless something is done now, more and more physicians are likely to retire, go into specialties other than primary care, or limit the number of Medicare patients they are willing to see. Enactment of H.R. 4475 would help restore physician confidence in the program and by doing so assure adequate access to primary care services in the future.

In the next few weeks, ASIM will be releasing a new white paper, titled "The Hassle Factor: America's Health Care System Strangling in Red Tape," which will more fully explain the adverse impact of the problem on patient care. It also presents a comprehensive series of recommendations, including additional legislation, to reduce the hassle factor. A copy of the paper will be provided to the committee. We urge the committee to report Mr. Rowland's bill and then take additional steps, as outlined in that paper, to reduce the paperwork and red tape that threatens to destroy America's health care system.

Summary and Conclusion

In conclusion, ASIM believes that the decisions that Congress makes this year will have a critical impact on the future of the Medicare program. If Congress agrees to further deep cuts in the program, permits fees for already-undervalued physician services to be slashed in 1991, allows the administration to regulate physician office labs out of existence, does nothing to arrest the growing hassles of Medicare, and allows physician payment reform to be implemented in a

manner that betrays the promise of improved payments for undervalued services, then these actions will trigger a profound sense of disillusionment, distrust, and despair among the physician community. Inevitably, this will harm access to care. On the other hand, if Congress makes a commitment to adequately fund Medicare, to avert any unintended rollback in fees for undervalued services, to maintain access to quality laboratory services, to reduce the hassle factor, and to preserve the integrity and promise of physician payment reform, then this will be a powerful signal to the medical community that Congress will do its part to maintain access to care. The result would be a renewed commitment on the part of the profession to the Medicare program.

Specifically, ASIM urges the committee to:

1. Reject further cuts in the Medicare program that would endanger physician payment reform and access to care. Medicare has contributed more than its fair share already to deficit reduction. It's time that Congress look to other program areas, and new sources of revenue, to reduce the deficit.

2. Allow a full prevailing charge update for primary care services and at least a partial update for hospital visits. Congress should reject the view, however, that as long as the reductions are taken from overpriced procedures, there will be no adverse impact on payment reform.

3. Reject the administration's proposal to establish a discriminatory method of payment for new physicians.

4. Maintain access to timely, accurate, and convenient laboratory services by (a) rejecting reductions in reimbursement that, coupled with the costs of complying with new regulatory requirements, could lead to closure of physician office labs; (b) exercise oversight of HCFA's implementation of CLIA '88 to ensure that it meets Congress' intent of improving accuracy while maintaining access; and (c) reinstate the moratorium on competitive bidding for laboratory services.

5. Reject the administration's proposal to coerce physicians into accepting assignment through hospital participation agreements that would be binding on the institution's entire medical staff.

6. Decline to support the administration's proposal to permit carriers to exercise prior authorization review until it can be shown that the carriers are able to administer existing review requirements in a more effective, efficient, fair, and open manner.

7. Strongly oppose the administration's proposal to charge physicians for submitting paper claims to Medicare.

8. Avert any 1991 rollback in physician fees for undervalued evaluation and management services.

9. Provide greater direction to HCFA on implementation of the RBRVS fee schedule. Specifically, instruct HCFA on how to calculate a "budget neutral" conversion factor, in order to assure that unfounded assumptions of a behavioral offset are not employed to eliminate most of the gains in payments promised when Congress enacted OBRA '89.

10. Report the Physician Regulatory Relief and Improvement Act as one essential part of a comprehensive strategy to reduce the "hassle factor."

ASIM stands ready to assist the committee in any way possible in meeting these objectives.

STATEMENT

OF THE

COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to comment on recommended budget cuts and Medicare policy initiatives for 1991. The College is a national medical specialty society representing more than 11,000 pathologists who practice medicine in community hospitals, academic medical centers, independent laboratories, and other settings.

College comments focus on Medicare physician services and laboratory policy reimbursement initiatives that are ill-conceived and inequitable. Our comments also address some Administration 1991 budget proposals that will be unnecessarily burdensome and costly to the federal government and suggest remedies for other such policies that are currently in effect.

1991 Relative Value Scale for Pathology Services

The Omnibus Budget Reconciliation Act (OBRA) of 1989 included two major RVS provisions that affect pathologists. Section 1848 was added to the Social Security Act to establish a relative value scale fee schedule for all physicians' Medicare services effective January 1, 1992. This fee schedule will be implemented or phased-in over a five-year period, and it will be based on an RVS determined by combining physician work (resources) values, practice expense values, and malpractice values into one relative value for each service.

The OBRA 1989 also amended Section 1834 of the Social Security Act to implement a budget neutral RVS-based fee schedule for pathology services effective January 1, 1991, subject to Section 1848 above. The pathology fee schedule is to be based on relative values developed by the Secretary in consultation with organizations representing physicians performing pathology services.

Professor William Hsiao and his colleagues at the Harvard University School of Public Health are conducting a restudy of physician resources involved in pathology services. The restudy, funded by the College, is scheduled to be finished in late 1990. In addition, the College has contracted for a study of pathology practice costs in different practice settings.

The College believes that the Hsiao pathology relative values should undergo a critical review and refinement process following completion of the Hsiao study. The College is committed to development of appropriate relative values for pathology and to review and revision of any proposed RVS to ensure its appropriateness.

Implementation in 1991 of a pathology fee schedule, followed by implementation in 1992 of a fee schedule for all physicians including pathology, is not in our opinion sound Medicare policy. The 1991 pathology fee schedule will only cause unnecessary work for the Medicare program and unnecessary disruption for pathologists. There is no benefit to this initiative.

The College of American Pathologists opposes implementation of any RVS fee schedule for pathology services until the Hsiao restudy of pathology services is completed and subjected to rigorous review. The College believes that implementation of the pathology RVS should be postponed pending completion and analysis of Hsiao and other studies currently under way. Implementation on January 1, 1991, of an RVS developed by the Secretary will not allow for careful review of the Hsiao restudy data and of its appropriate use in developing an equitable RVS for pathology services.

In its 1990 Report to Congress the Physician Payment Review Commission agreed that, rather than implementing a 1991 fee schedule, pathology services should be paid on the basis of the resource-based fee schedule being developed for all physician's services and scheduled for implementation in 1992.

On June 26, 1990, the House Ways and Means Health Subcommittee approved repeal of the OBRA 1989 requirement for a 1991 pathology RVS-based fee schedule.

The College urges this Subcommittee to support repeal of the 1991 pathology fee schedule provision.

PPRC Proposed Reduction in Pathology Prevailing Charges

The Physician Payment Review Commission (PPRC) recommends an average reduction in anatomic pathology prevailing charges of up to 4 percent, with consideration of geographic variation to protect pathology charges already below some threshold. The 4 percent reduction would be in addition to foregoing the scheduled Medicare Economic Index (MEI) update for 1991 recently estimated by the Administration to be 3.2 percent. Thus, the real 1991 reduction in pathology prevailing charges would be in excess of 7 percent. The recommendation is based on estimates of reductions in payment for pathology services derived from flawed Hsiao Phase I RVS data that is the subject of a restudy now underway. Restudy results will be available for use in RVS implementation in 1992.

The overall reduction in Medicare payment for pathology services predicted on the basis of Hsiao Phase I data was the result of enormous reductions in the value of a small number of very high volume (for pathology) services. In fact, other pathology services were considered undervalued in Hsiao Phase I and would receive increases were those data the basis of a relative value scale.

The services that would be reduced significantly – surgical pathology – are the services for which the Hsiao data are most questionable and the services for which the restudy revisions are most substantial. We urge you to allow that process to be completed and reviewed before any reduction in pathology prevailing charges is instituted.

We believe it is inequitable to subject pathology to such a substantial reduction in one year on the basis of data about which there are so many uncertainties and which are the subject of a significantly revised restudy.

We appreciate that other specialties expected to receive Medicare payment reductions with relative value scale implementation have already experienced some cuts and may see their reimbursement reduced again this year. Likewise, pathology has already undergone physician payment reform in implementation of the Tax Equity and Fiscal Responsibility Act (TEFRA) and the Medicare hospital Prospective Payment System (DRGs) in 1983. The combined effect of these two major laws significantly reduced Medicare payment to pathologists for their work in a hospital setting and set in motion Part B (BMAD) data and payment problems that are still being resolved with the Health Care Financing Administration and Medicare carriers. The result is that pathologists net income, as reported by the AMA *Socioeconomic Monitoring System,* is now below the average for all physicians.

Pathologists were the first to experience Medicare payment reductions, not the last.

Problems in implementing the Commission recommendation to rationalize the average reduction of 4 percent with geographic variations further illustrate the need to await RVS results before changing payment for pathology services. In particular, variations in current use of surgical pathology billing codes make it impossible to identify with confidence geographic areas of true low payment and high payment. The primary reasons for this difficulty are:

1. **Variation in assignment of pathology cases to CPT codes.** In some areas all cases of one type are assigned to one code; in other areas such cases are assigned to a different code; in still other areas code assignment is determined by the physician and varies by case complexity.

   Hsiao vignette assignment and case coding guidelines under development by the College for use in RVS implementation will clarify the appropriate codes for various services.

2. **Variation in the number of codes (units of service) billed for each pathology case.** In some areas all pathology specimens removed during one surgical procedure must be billed under a single CPT code. In other areas multiple codes (units of service) are used to identify multiple specimens requiring individual and separate attention, examination, and diagnosis. Current reasonable charge payment levels (e.g., prevailing charges) do not necessarily appropriately reflect variations in unit-of-service billing because of constraints on charges for pathology services during the last decade.

   Hsiao vignette description and subsequent CAP coding guidelines will provide a basis for determining the unit-of-service.

3. **Fragmentation versus bundling of associated or related services.** In some areas payment for special stains or other adjunctive diagnostic techniques is included in payment for the primary surgical pathology service/code. In other areas associated services are coded and reimbursed under separate prevailing charge profiles.

Uniformity in payment to accompany RVS implementation in 1992 should address this issue.

Thus, what could appear to be inappropriately low or high current payment levels (prevailing charges) relative to a geographic practice cost index or some other measure, may in fact be differences in payment levels for very different services billed under the same CPT code.

There is no database with which to rationalize reductions in current Medicare pathology prevailing charges to protect true low charge levels and reduce true higher charge levels .

The College urges the Subcommittee to reject the proposal to subject pathology prevailing charges to a 4 percent reduction in 1991 (7+ percent including the foregone MEI update) and to await Hsiao restudy data and final relative values scheduled for implementation in 1992.

Attachment A discusses additional reasons to reject proposed reductions in 1991 pathology prevailing charges.

Competitive Bidding for Clinical Laboratory Services

Competitive bidding for clinical diagnostic laboratory services has been a topic of debate in Congress for more than five years. In the past, Congress has imposed a moratorium on competitive bidding demonstrations proposed by the Administration because of the unacceptable risk of disrupting beneficiary access to quality laboratory services.

The moratorium has expired because it was inadvertently omitted from budget reconciliation legislation in 1989. The Administration is again seriously considering conducting competitive bidding demonstrations for clinical laboratory services in 1991. This illogical plan appears to stem from the notion that medical diagnostic services can be bid, bulk purchased, and provided in much the same manner as manufactured supplies and equipment.

In fact, competitive bidding for clinical diagnostic laboratory services will invite reductions in quality and access to these services for Medicare beneficiaries. Even as a demonstration project, a competitive bidding program for diagnostic services would be administratively burdensome, expensive to implement, and enormously disruptive in the demonstration areas. According to the federal agency developing the plan, it would be impossible to replicate nationwide.

It is highly questionable whether realistic prices for clinical diagnostic laboratory services would be the result of such a demonstration. More likely, laboratory medicine would be disrupted in the demonstration areas, access and quality would be jeopardized, and no insight into appropriate pricing for laboratory services would be gained. This disruption would come at a time when laboratories will be

adjusting to significant changes in Medicare Conditions of Participation and incurring substantial increases in cost of test provision.

The Medicare program already controls the pricing of clinical laboratory services through the clinical laboratory fee schedule. Competitive bidding is not necessary.

The College urges the Congress to prohibit competitive bidding for clinical diagnostic laboratory services, both as a demonstration project and as a Medicare payment policy.

Medicare Clinical Laboratory Fee Schedule

In 1984, Medicare payment for outpatient clinical diagnostic laboratory services was reformed, and a fee schedule was implemented. In almost every year since then, the fee schedule has been subjected to reductions, caps, elimination of inflation updates, or other restrictions. Currently, Medicare payment for clinical laboratory services is based on carrier-specific fee schedules and limited by service-specific national caps that are 93 percent of the median of all such fee schedule amounts.

The Administration now proposes further reducing the national caps to 90 percent of the median for most services and to 80 percent of the median for services provided as standardized test packages or profiles. The 1991 inflation update would be eliminated except for fee schedule amounts below the caps. Data on prices charged for services to non-Medicare patients would be used to reduce Medicare fee schedules in subsequent years.

Payment for Medicare clinical diagnostic laboratory services cannot be subjected to such additional reductions without sacrificing quality and access. Attachment B lists major legislative changes that have restricted payment for Medicare clinical diagnostic laboratory services.

The College urges the Congress to allow a period of stability in Medicare payment for clinical laboratory services by rejecting the Administration's proposals for 1991. The Medicare clinical laboratory fee schedules should receive the full scheduled inflation update for 1991 and should not be subjected to reductions in the national caps.

Data on non-Medicare charges for these services is unsuitable for use in setting fee schedule amounts for services to beneficiaries of the Medicare program which imposes extensive billing and payment restrictions on providers. Non-Medicare payers often allow batch billing (which reduces billing costs) and do not require the extensive reporting that the Medicare program demands.

Medicare Payment for Graduate Medical Education

The federal government supports graduate medical education (GME) of the nation's physicians through payment to hospitals for their direct and indirect costs in this regard. Since 1983, payment for indirect medical education costs has been included as an element of the hospital prospective payment system (PPS) with payments to qualifying teaching hospitals increased 7.7 percent for each 0.1 increase

in the hospital's ratio of interns and residents to beds. This adjustment is to compensate teaching hospitals for higher costs in patient care associated with the training of physicians that are not accounted for in the PPS rates.

Direct medical education costs (salaries and other overhead costs) are reimbursed separately but also prospectively, based on the hospital 1984 cost per resident adjusted for subsequent increases in the level of consumer prices. Although these payments represent only about 2 percent of Medicare inpatient payments, one-sixth of hospitals receive this reimbursement and it is estimated by the Congressional Budget Office to cover one-third of hospitals' total graduate medical education costs.

The Administration proposes to reduce payment for both direct and indirect graduate medical education. The reduction in the indirect GME payment would be a significant reduction in the adjustment factor from 7.7 percent to 4.05 percent. The direct GME reduction would be achieved through establishment of a per resident payment derived from 1987 resident salary data. The result would be a reduction of $205 million in payment in direct GME costs in 1991. This reduction would occur when the impact of 1985 legislation revising payment for direct GME is uncertain because of delay in implementation.

Such reductions in payment to hospitals that conduct essential training programs for physicians will cause erosion of the nation's medical education system and undeserved hardship on teaching hospitals, which also care for a disproportionate share of indigent patients. Hospital closures or reduction of residency positions is likely to result. Access to needed health care services in some communities will be reduced.

Pathology residency programs would be particularly affected by the proposed reductions. The average age of pathologists is now 52 years, with the average age of retirement 62 years. A large proportion of pathologists are expected to retire by the end of this decade, and there is no current surplus of pathologists to fill the void left by the retiring pathologists. In fact, there is a serious shortage of pathology residents at this time. A shortage of pathologists is predicted for the mid-1990s. With continual decreases in GME payment it is increasingly difficult for hospitals to maintain residency programs that would train pathologists for the future.

The College urges the Congress to continue support of needed physician training programs by opposing the severe cuts for these services proposed by the Administration.

Regulatory Relief Amendments of 1990

The College supports H.R. 4475, the Medicare Physician Regulation Relief Amendments of 1990.

This bill would relieve physicians of certain technical claims submission requirements that hamper access to care, improve communication between physicians and

Medicare carriers regarding payment criteria and rules, and involve health care providers in development of payment rules.

In particular, H.R. 4475 would:

- Permit physicians in different practices to provide occasional coverage for each other and allow the personal physician of the patient to bill and receive reimbursement for services provided by the covering physician(s). This provision will facilitate coverage and access in rural areas and remove the confusion and administrative expenses of billing for one-time-only or occasional service.

- Require release of criteria used to deny claims.

- Prohibit Medicare carriers from charging physicians for identification numbers, maximum allowable charges, coding protocols, and other information needed for claims processing.

- Allow medical societies and other professional organizations to represent a group or class of physicians in payment determinations, reconsiderations, or appeals.

- Establish a Practicing Physicians Advisory Council to advise the Health Care Financing Administration on proposed changes in Medicare coverage, benefits, and operations policy.

Voluntary Hospital Physician Participation

The Administration proposes to allow hospital administrators to sign an agreement with the Medicare program guaranteeing that assignment would be accepted for emergency services, radiology, anesthesia, pathology services, and consultations by all physicians. A hospital would be able to advertise its status as a Medicare "participating medical staff hospital" in an attempt to compete with other nonparticipating hospitals.

The College opposes expansion of Medicare assignment authority for physician services to non-physicians – the Voluntary Hospital Physician Participation Proposal.

The Medicare program will soon implement a major change in the manner in which physician services are reimbursed--the Medicare Fee Schedule (MFS) based on resources. Stringent limitations on balance billing for unassigned services will accompany the MFS.

To impose upon this new payment system a program in which hospitals have vague competitive or economic incentives to pressure the entire medical staff to accept assignment is an invitation for medical staff–hospital disruption and misunderstanding. If medical staffs wish to voluntarily accept assignment, they may do so now and join the hospital in such an advertising campaign.

The Voluntary Hospital Physician Participation program should be rejected as divisive to physicians and hospitals and unnecessary to protect Medicare beneficiaries.

User Fees for Health Facility Survey and Certification

The Administration proposes to tax health care facilities, in the form of a "user fee," for performing survey and certification procedures required to ensure that the facilities adhere to Medicare conditions of participation. The fees would be used to fund expected increases in federal survey and certification activities required by the Clinical Laboratory Improvement Amendments of 1988 and other laws, including hiring of an additional 170 full-time equivalents to perform these services.

It is not necessary to tax health care facilities for laboratory inspection and certification provided by the private sector. The private sector, in cooperation with the Department of Health and Human Services, has historically provided these services without imposing federal fees and has the capability to continue to do so.

Laboratory medicine has a long history of regulation, inspection, and certification by the Medicare program. Inspection and accreditation of health care facilities is conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The College of American Pathologists Laboratory Accreditation Program (CAP-LAP) inspects and accredits more than 4,000 hospital and independent laboratories. The JCAHO accepts CAP-LAP accreditation, and JCAHO accreditation is accepted by the Medicare program as meeting its requirements. These private sector programs provide a valuable response to federally mandated standards and are viable alternatives to federal user fees for the same purpose.

Likewise, the Commission on Office Laboratory Assessment (COLA), a collaborative effort of the College of American Pathologists, the American Academy of Family Physicians, the American Society of Internal Medicine, and the American Medical Association, was created to provide accreditation for physician office laboratories.

The College believes that these private sector approaches represent a desirable and appropriate alternative to costly government survey and certification of laboratories. It is not necessary to impose federal user fees on laboratories to finance laboratory accreditation activities. The private sector has demonstrated the ability and willingness to undertake this activity at no cost to the federal government. The programs should be encouraged and their involvement enhanced through granting of Medicare "deemed status" applications.

The user fee proposal should be structured to ensure that survey and certification activities provided by the private sector are not duplicated and health care facilities are not doubly charged.

Conclusion

The College of American Pathologists encourages the Subcommittee to consider carefully budget deficit initiatives and premature payment reforms aimed at laboratory medicine and to reject them. In particular:

- ***The requirement for a 1991 pathology RVS-based fee schedule should be repealed.***
- ***The proposal for a 4 percent reduction in 1991 pathology prevailing charges should be rejected.***
- ***Proposals for competitive bidding for Medicare clinical laboratory services should be prohibited and further reductions in the fee schedules for these services should be avoided.***

These initiatives, if implemented, will threaten the ability of the nation's health care facilities to provide quality laboratory medicine. Laboratory medicine cannot continue to be the target of budget reductions, payment restrictions, caps, user fees, "competition" initiatives, and increased regulatory rules, year after year, without jeopardizing these services.

The College encourages the Subcommittee to oppose cuts in Medicare GME payments and to reject the ill-conceived Voluntary Hospital Physician Participation Program.

The College supports H.R. 4475, the Medicare Physician Regulation Relief Amendments of 1990, that would simplify claims processing requirements and improve communication between physicians and the Medicare program.

As always, the College is ready to work with the Subcommittee to ensure high quality laboratory medicine.

The College appreciates the opportunity to comment in 1991 Medicare budget proposals.

USER\SMW\27JUL90.TST

ATTACHMENT A

REASONS TO REJECT PROPOSED REDUCTIONS IN 1991 PATHOLOGY PREVAILING CHARGES

There is no objective basis for reducing Medicare prevailing charges for anatomic pathology services.

1. Current variations in Medicare coding and payment policy for anatomic pathology services make it technically impossible to identify with confidence true high and low payment areas.

   Any change in Medicare payment for anatomic pathology should await Hsiao pathology restudy and RVS completion in late 1990. Hsiao data and subsequent CAP development of uniform case coding guidelines will clarify coding and payment policy for implementation in 1992.

   Premature assumptions about Medicare payment for pathology services are not sound policy.

2. The Physician Payment Review Commission's 1990 *Report to Congress* agreed that pathology physician work values may change substantially during the restudy by Hsiao and colleagues (page 291).

3. Access to surgical pathology in rural areas will be endangered by groundless reductions in pathology prevailing charges. Pathologists often commute from urban areas to serve the needs of rural hospital patients. OBRA 1989 requires study of the special circumstances of rural pathology services — that study is not complete.

4. Medicare average allowed amounts for pathology services are modest, particularly when compared to the type of service provided. These procedure codes account for 60 percent of the volume of pathology services:

Average Allowed Charge		Service
$28	88302	Gross and microscopic examination of tissue presumed to be normal. Example: a herniated intervertebral disc is removed to reduce pain and neurological loss. The herniated tissue is examined for evidence of unexpected disease including metastatic neoplasm which is more common in the elderly than in other age groups.
$36	88304	Gross and microscopic examination of tissue presumed to be abnormal. Example: Hemorrhoids are removed to eliminate symptoms of pain and bleeding. The pathologist examines them for presence of primary or secondary malignancy which is present in a percentage of cases.
$58	88305	Example: Gross and microscopic examination of pieces of tissue from the uterus of an elderly woman with bleeding to determine the presence or absence of cancer or another disease process.
$24	88104	Example; Cytopathologic examination of sputum to determine the presence or absence of malignant cells or other abnormality for a patient who has a lung mass on x-ray.
$23	80500	Example: Consultation regarding abnormal enzyme levels for a patient with suspected liver disease.

(Source: CY1988 Medicare Part B Procedure File, BMAD I)

5. Pathologists income is already below the national average income for all physicians and is rising at only half the rate of increase for all physicians. (Source: AMA, *Socioeconomic Characteristics of Medical Practice 1988, 1989*)

Pathology prevailing charges should not be reduced in 1991. Any revision to pathology Medicare prevailing charges should await completion and review of the Hsiao restudy.

USER\SMW\PREVAIL.ATT

ATTACHMENT B

Major Restrictions on Payment for Medicare clinical laboratory services:

July 1978: Lowest Charge Level

Established lowest charge level for selected clinical laboratory tests at the 25th percentile of charges for services in the locale.

July 1984: Clinical Laboratory Fee Schedule

Mandated that clinical laboratory services performed in hospitals for outpatients; in physicians' offices; and in independent laboratories be paid on the basis of a carrier-wide fee schedule. Payments were set at 60% of prevailing charges for independent labs and physicians' offices; and at 62% for hospital outpatients. (Independent laboratories and hospital labs required to accept assignment in order to receive payment from Medicare.)

Congress required that the GAO and the Secretary of HHS report on the impact of the fee schedule; and on the appropriateness of moving to a national fee schedule for hospital labs.

Lowest Charge Level for selected clinical laboratory tests (above) repealed.

July 1, 1986: Fee Schedule Cap

Clinical laboratory fee schedule capped at 115% of median of all fee schedules across Medicare carriers.

January 1, 1987: Differential Eliminated

2% differential between independent labs and physician office labs (paid at 60%) and hospitals (paid at 62%) eliminated, except for hospitals with 24 hour, 7 day a week emergency room services.

Physicians' office labs required to accept assignment.

January 1, 1988: Update in Fee Schedule Eliminated

OBRA 1987 eliminated the scheduled inflation increase in fee schedule amounts for 1988.

April 1, 1988

2% differential eliminated for all hospital laboratories except those located in sole community hospitals (and only if the lab operates 24 hours a day, 7 days a week).

Fee schedules for certain automated and other high volume tests (e.g., urinalysis, CBC) were reduced by 8.3%.

The national fee schedule cap was reduced to 100% of the median of all fee schedules.

OBRA 1989 - Effective January 1, 1990

A reduction of the national fee schedule cap to 93% of the median.

STATEMENT OF THE NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, COMMITTEE ON ENERGY AND COMMERCE ON PROPOSALS TO REDUCE OUTLAYS OF THE MEDICARE PROGRAM
July 27, 1990

I. INTRODUCTION

The National Association of Portable X-Ray Providers (NAPXP) submits this statement on proposals to reduce Medicare outlays. The Association is a ten-year old organization representing suppliers of portable x-rays throughout the United States. The NAPXP is vitally concerned about Medicare budget actions because over 90 percent of portable x-ray services are reimbursed by Medicare. Thus, the NAPXP respectfully urges the Committee to consider its views.

II. BACKGROUND ON THE PORTABLE X-RAY SERVICE AND MEDICARE REIMBURSEMENT

A. The Nature of the Portable X-Ray Service

Portable x-ray suppliers are companies that bring x-rays to the bedsides of elderly homebound or nursing home patients. Typically, they are small, literally "Mom-and-Pop" firms founded by former x-ray technologists who remain closely involved in the day-to-day business. Portable x-rays are performed entirely by x-ray technologists, with no physician involvement in the taking of the x-ray or transportation of the equipment to patients. Thus, portable x-rays are not physicians' services. (The films are sent to outside, unrelated physicians for interpretation only.)

The only alternative to the portable x-ray service is transporting the patient in an ambulance to a hospital, which entails potentially injurious physical movement and mental trauma. The portable x-ray service generally costs one-third to one-fourth as much as the ambulance alternative, and provides a faster turnaround of films to the attending physician, thus speeding diagnosis and treatment of injuries. Portable x-rays are functionally different from physicians' office x-rays and much costlier to provide because of the special difficulties created by, and training required for, a geriatric, infirm clientele and the need to transport the x-ray equipment and then assemble, dismantle, and reassemble it for each patient who is x-rayed.

B. History of Medicare Reimbursement of Portable X-Ray Services

Portable x-ray services have been covered by Medicare since early in the history of the Medicare program, and have been recognized by statute as non-physicians' services. See 42 U.S.C. §1395x(s)(3). Similarly, the Health Care Financing Administration (HCFA) devised a unique payment instruction for portable x-ray services that is embodied in a separate section (5244) of the Medicare Carriers Manual.

Notwithstanding this recognition of the portable x-ray service by Medicare program authorities as a unique, non-physician's service, the portable service has been ignored or misunderstood by the local Medicare carriers because of the relatively miniscule size of the business: portable x-rays represent less than 2 percent of all Medicare radiology procedures. Consequently, Medicare carriers in many parts of the country have historically treated portable x-ray services incorrectly as physicians' services, despite many efforts by portable x-ray suppliers to explain that physicians are not involved in providing the service and that it does not resemble the type of x-ray normally provided to ambulatory patients in physicians' offices.

This historical misunderstanding by carriers has been reflected in two ways. First, many carriers erroneously subjected portable x-ray suppliers to the Medicare physicians' fee freeze of 1984-1986. Second, throughout the 1980s carriers historically reimbursed portable x-ray suppliers, contrary to the direction in Section 5244 of the Carriers Manual, by "commingling" portable x-ray charge data with physicians' office x-ray charge data in determining prevailing charges. Because portable x-rays are much costlier to provide than physicians' office x-rays, portable x-ray charges are necessarily higher than those for physicians' office x-rays. Consequently, the commingling of portable x-ray charge data for 2 percent of procedures with physicians' office charge data for 98 percent of procedures created prevailing charges for portable x-ray services that were lower than they would have been if only portable x-ray data had been used. HCFA itself stated in 1985 that the carrier "commingling" practice was improper, but carriers continued to use it.

Because of these historical errors, Medicare portable x-ray payments throughout most of the 1980s were suppressed below even correctly calculated Medicare payment levels--while staff salaries and other costs of doing business continued to rise. In 1986, pursuant to the Inflation Indexed Charge (IIC), portable x-ray payments were again subjected to a freeze, so that Medicare payment levels fell even further behind cost increases.

Before 1988, the general principle for reimbursement of portable x-ray services was the "reasonable charge" method that set Medicare payment at the lowest of the actual, customary, and prevailing charges. In the Omnibus Budget Reconciliation Act of 1987 (OBRA'87), Congress mandated a new fee schedule reimbursement methodology for physicians and "suppliers" of radiology services. 42 U.S.C. §1395m(b). The new law directed HCFA to develop a relative-value-based fee schedule for all such radiology services and to cut payments for radiology services in each locality by 3 percent.

It was at this point that the NAPXP first approached HCFA to discuss the portable x-ray business and explain the considerable differences between portable x-ray services for infirm, elderly patients and physicians' office x-rays for ambulatory patients. HCFA recognized these functional differences and the fact that the portable x-ray service is not in any way a physician's service. Consequently, HCFA established a separate fee schedule solely for reimbursement of portable x-ray services (incorporating the Congressionally mandated 3 percent cut). Additionally, the agency made a commitment to resolve the historical "commingling" problem, albeit after the initial implementation of the portable x-ray fee schedule. HCFA officials are now developing a methodology for carriers to use in correcting the commingling problem. (However, the problem is complex, and the implementation of HCFA's corrective methodology by carriers may be a difficult and time-consuming process.)

In 1989, the Administration proposed and Congress enacted a 4 percent payment cut for radiology services. During the Congressional consideration of these payment cuts, the NAPXP argued that they should not apply to portable x-ray services. The NAPXP pointed out that portable x-ray services are not physicians' services, and that portable x-rays cannot be considered "overpriced" because of the historical suppression of portable x-ray reimbursement. In addition, the NAPXP argued that portable x-rays are by far the most efficient and effective means of providing x-rays to nursing home and homebound patients. Thus, the NAPXP showed that it is in the interests of the Medicare program, with regard to both cost and quality of service, to encourage the continuation and expansion of the portable x-ray service through adequate Medicare payment rates. Ultimately, Congress accepted these arguments and treated portable x-rays as non-physicians' services that were excluded from the 4 percent cut. See Section 6105 of OBRA'89. However, portable x-ray services received no update in OBRA'89, notwithstanding the 3 percent cut mandated by OBRA'87 and the erroneous historical suppression of portable x-ray reimbursement through the erroneous application of the physicians' fee freeze and "commingling."

III. ADMINISTRATION BUDGET PROPOSALS FOR FISCAL YEAR 1991

This year, the Administration has again proposed to cut Medicare payments for radiology services. The Department of Health and Human Services (HHS) budget proposal for FY'91 states:

> In OBRA'89, the Congress reduced payments for radiology and anesthesia services: radiology fees were reduced by 4 percent and changes were mandated in payment for anesthesia time. For 1991, we are recommending reductions in Medicare payments for radiology and anesthesia services in order to further reduce their overvaluation.
>
> We are proposing that radiology and anesthesia fees be reduced by the amount that current fees exceed an estimated resource based fee schedule. The fee schedule would be estimated by reducing the 1990 national average conversion factor by 10 percent (less than the full amount we estimate these services are overvalued). The maximum reduction for any locality in 1991 would be 25 percent.

HHS Press Release on Budget Proposals for the Medicare program (January 29, 1990) at 49-50. This language describes "radiology" services as those that were cut last year by 4 percent. Portable x-rays were not covered by that cut. Thus, it is appropriate to conclude that the "radiology" services that the Administration proposes to cut this year are limited to the physicians' radiology services that were cut in OBRA'89.

The Administration has also proposed to cap the "technical components of diagnostic and radiology tests" by applying a median-based national limitation similar to that imposed on clinical laboratory reimbursement since 1986. Again, the Administration proposal discusses "radiology" services. We believe it is appropriate to interpret this proposal as applying only to physicians' radiology services, not portable x-rays, because portable x-rays are not overpriced.

IV. CONGRESS SHOULD NOT LIMIT MEDICARE PORTABLE X-RAY PAYMENTS THIS YEAR.

In view of Congress' decision in OBRA'89 to treat "radiology" services as not including portable x-ray services for purposes of cuts, we believe portable x-ray services should again be excluded from the proposals for radiology payment cuts this year. Further, due to the erroneous application of the 1984-1986

physician's fee freeze and the effects of the 1986 IIC freeze, the OBRA'87 3 percent cut, and the OBRA'89 freeze, Medicare portable x-ray reimbursement--which controls the destiny of the industry--has lagged farther and farther behind cost increases. A payment increase is sorely needed. Portable x-rays should, therefore, receive a full Consumer Product Index (CPI) update in FY 1991. Such a change would be consistent with Congress' recognition last year that Medicare's policy interests favor encouraging this cost-effective service.

The appropriateness of a "hands-off" policy for portable x-ray services this year is underscored by the pendency of HCFA's project to correct the historical effect of "commingling." This project should be finished, and its impact on portable x-ray reimbursement assessed, before any additional cuts or freezes are imposed. Further, another important project should be completed before Congress makes any further decisions about payment limitations for portable x-rays. This project is a study, mandated by Congress in OBRA'89, of the costs of furnishing portable x-ray services and the appropriateness of the separate portable x-ray fee schedule. See Section 6134 of OBRA'89. The study is due in December 1990. Its results will bear directly on questions regarding the appropriate level of portable x-ray reimbursement. Congress should have the benefit of the study before any decisions about payment cuts are made.

Finally, if any proposals are made to include portable x-rays in radiology payment cuts or limitations, it is imperative to take a close look at the numbers. Because portable x-rays constitute only 2 percent of Medicare radiology services, reimbursement cuts for this service would provide negligible deficit reduction benefits. Conversely, a long-overdue payment increase would impose minimal cost. But because Medicare pays for over 90 percent of all portable x-rays, any Medicare payment cuts can impair the health of the portable x-ray business. The industry is already vulnerable because so many of its members are small shops, payments have fallen far behind costs throughout the 1980s, and there is a serious nationwide shortage of portable x-ray technologists. Reimbursement limitations, on top of these existing pressures, could drive many of the smaller companies out of business. Congress should not risk compromising the availability of this highly cost-effective Medicare service by subjecting it to payment limitations. Instead, Congress should sustain the portable x-ray service by granting a full update.

V. CONCLUSION

Congress' decision last year to exclude portable x-rays from payment cuts rested on important legal, economic and policy considerations that have not changed. Congress should take the same position in FY 1991 by excluding portable x-rays from any radiology payment cuts or limitations and directing a full CPI update for this valuable service.